AUTHORIZED CHILD CARE PAYMENTS
February 20, 2009 – P.T 2009.02

PROCEDURES 359

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// **Section 359.10 Purpose**

// **Section 359.20 Definitions**

// **Section 359.30 Introduction**

The following procedures correspond to the services described in Part 359 for which the Department makes payments. The procedures for each service or item are organized by:

1) **Type Service Code** which is a unique four-digit code used to identify the type of placement, service or item for which payment is being made (also see Table CFT BL 1018 available from the Information Services Division);

and

2) **Instructions** which describe the purpose of the payment and other information necessary for making the payment.

Other factors, such as Age Level, Approval Level, and Preconditions for Payment, generally remain constant for all payments. Any exceptions will be noted in the Instructions.

Age Level: For most services the Age Level extends to children under 21 years of age.

Approval Levels: The Director's approval is generally required for contracts and approval of the supervisor for payment documents. Some services require approval by a higher-level authority then the supervisor, such as Regional Administrators or designee such as for **CFS 906-4, Special Service Fee and Payment Extension Form** and **CFS 902, Exceptional Payment Requests**. The payment document itself requires the actual signature of the person that has personal knowledge of receipt of goods and/or services (generally the caseworker).

Preconditions: Preconditions refer to certain prerequisites or conditions that must exist before certain payments can be made. The most common type of precondition will be that a case must first be registered and opened before a payment can be made on behalf of a child or family. For some services a provider must be licensed and/or a contract must be in place before payment can be made to the provider. For payments to a single provider that exceed $9,000 but are less than $9,999, the vouchers are submitted to the Business Manager for processing. **A contract is required if a single provider is to be paid more than $10,000 in one fiscal year.**

For payments to child care institutions or group homes, a DCFS Child and Youth Investment Team (CAYIT) review has to be made prior to placement of a child in the residential care or group home.

Payment Document: A payment document is the particular form used to process a payment. There are seven major types of payment forms used:

1) Placement/Payment Authorization Forms **(CFS 906 or 906-1)** which are used to initiate or change payments for the child's living arrangement;

2) Purchase Authorizations **(CFS 932)** which are used to authorize purchases for goods or services for a child;

3) Forms necessary to authorize payment for certain services such as homemaker, counseling or day care services **(CFS 1042, CFS 420-21-A and B)**;

4) Special Service Fee and Payment Extension Form **(CFS 906-4 or CFS 906-5)**;

5) Invoice Voucher **(C-13)**;

6) Travel Voucher **(C-10)**.

The payment document for each particular service will appear next to the Type Service Code throughout these procedures. For detailed instructions on the use and completion of these payment forms, refer to "Fiscal Unit Procedure Manual."

Authorized Rates: Authorized rates are allowable payment amounts for all items. These rates are contained in Appendix A.

Account Code: The Account Code is the appropriations account number that describes what budgetary line is used for payment of the particular service or item. Account codes are identified in Tables CFTB 1148 and 1122 available from the Information Services Division.

SUBSTITUTE CARE SERVICES

Basic Payment Provisions

Payment is always made for the day of entry to the placement but not for the day of departure. Payment rates only apply when a child is in placement except that payment may be made for part or all of an absence for hospitalization, runaway, or incarceration, provided the Department has agreed the child shall be returned to the same placement from which he or she is absent. Payment may also be made for part or all of an absence for hospitalization due to substance abuse services and psychiatric services.

Prior to making any placement, the Placement Clearance Desk procedures contained in Procedures 301, Placement and Visitation Services, Appendix E must be followed.

How to Extend a Payment

In order to extend a payment, different forms must be used: the CFS 906 or CFS 906-1 and CFS 906-4 or CFS 906-5. First, the 906 or 906-1 is used to stop payment as of the effective date of the runaway, hospitalization or incarceration. The 906-4 or 906-5 is then used to extend payment to provider for which payment was stopped. For the 906-4 and 906-5, the start date of the payment extension may be the same as the effective date of the runaway, hospitalization or incarceration. Payment can be extended from 1 to 30 days depending on the reason for the payment extension, the type of the prior living arrangement and if the child was returned to their previous placement. If the child is placed in another living arrangement prior to the last date of the approved payment extension, the payment extension will only pay up through the day before the effective date of the new living arrangement. Payment extensions may not be made for placements which would cause the facility to exceed licensed capacity as a result of children being on runaway, hospitalized or incarcerated.

Service Codes

Each item of payment authorized by the Department under these procedures is assigned a four-digit Service Code number with the name specifying the payment for that particular Service Code. This Service Code must be entered in the document specified in the Procedures. See Appendix F for a list of Service Codes used in these procedures.

Section 359.40 Payments for Foster Family and Relative Home Care

Occupancy in licensed foster homes cannot exceed licensed capacity, except when approved by the Director for purposes of facilitating an adoption. (Refer to Rules 402, Licensing Standards for Foster Family Homes.) In addition, the ages of children placed within the home must fall within the capacity and limitations established by the family home licensing worker, and the license must be currently in effect or a renewal application filed in a timely manner.

a) Regular Department Boarding Homes

Type Service Code		Document
0101	Department Boarding Home (Traditional Home Care) (See Appendix A (I) (b) for amounts)	CFS 906
0107	Department Reduced Rate Boarding Home	CFS 906
0120	Intermittent Non-Contracted Foster Care (See Instructions below)	CFS 932
0151	Cuban-Haitian Refugee Clients	CFS 906
0152	Other Refugee Clients	CFS 906

Instructions: Regular Department boarding homes are licensed foster homes supervised by DCFS. Payment may be made using Type Service Code 0120 for weekend visits or vacations for children placed in regular Department foster care from state-funded Illinois Department of Human Services (IDHS) facilities that receive a clothing allowance for the child or for respite care for foster parents. See P.359.45 (f) of these procedures.

If a boarding home for some reason wants less than the usual full board payment, indicate Type Service Code 0107 and amount to be paid on the payment document. This also applies if children are receiving benefits directly (not yet directed to the Children's Benefit Fund), e.g. Social Security, Veterans benefits, which must be deducted from the 0101 rate.

b) Relative Boarding Homes (Department Supervised)

Type Service Code		Document
0106	Home of Relative	CFS 906
0115	Relative Homes - Reduced Rate	CFS 906
0153	Home of Relative - Cuban/Haitian Refugee	CFS 906
0154	Home of Relative - Other Refugee	CFS 906
0120	Intermittent Non-Contracted Foster Care	CFS 932

Instructions: Full board payments are made to licensed relatives (excluding parents) approved and supervised by DCFS to provide care for related children for whom DCFS has legal responsibility. See Rules and Procedures 301.60 for Department policy regarding placement in relative homes. Board payment may be made to unlicensed relatives. See Appendix A (I) (a) for rate amounts for Relative Unlicensed Home Care.

Use Type Service Code 0115 to indicate an agreed reduced amount and specify on CFS 906, Placement/Payment Authorization Form - Department Foster Care. Payment may be made using Type Service Code 0120 for weekend visits or vacations for children placed in relative foster care from state-funded facilities (IDHS) which receive a clothing allowance for the child or for respite care for foster parents. See P359.45(f) of these procedures.

c) Private Agency Foster/Relative Homes

1) Cook County Private Agency Relative Foster Care Performance Contract (PCC)

Type Service Code		Document
2140	Board Payment to the Foster Family: **Always use this Type of Service Code for 906 Entry of new placements in Private Agency Home of Relative (HMR) foster homes.**	CFS 906-1
2940	Monthly board rate for HMR licensed foster homes.	CFS 906-1
2640	Monthly support payment paid directly by DCFS to HMR foster homes that are not licensed.	CFS 906-1
2191	Estimated monthly board payment prepared by the Department's Division of Budget and Finance.	C-13
2198/2298	Payment to Private Agency for Administration prepared by the Department's Division of Budget and Finance.	C-13
2127	Assessment fee paid when the Department requests or approves an agency request for a special assessment because of an incomplete file or casework record.	CFS 1042
2401	Hourly rate for ongoing or extraordinary services such as reports, court appearances and services requested by the Department or required by the courts on behalf of children remaining at home.	CFS 1042
3033	Reunification casework services fee for children returned home.	CFS 1042
3034	Grant payment for reunification services, other than casework, based upon a detailed budget.	CFS 1042 & CFS 968-54

Instructions: The Division of Budget and Finance prepares the payment vouchers for Type Service Codes 2191 and 2198/2298. The private agency is responsible for initiating requests for payment related to all other Type Service codes. All board payments for HMR foster homes are initiated by the private agency using the CFS 906-1 Placement/Payment Authorization Form - Private Agency, Institution, Group Home, and Type Service Code number 2140. The DCFS Central Office Client Payment Unit identifies the correct service type code and rate based upon the information in MARS/CYCIS. For additional explanation of services and payments, refer to the Cook County Private Agency Combined Traditional and Relative Foster Care Performance Contract (PCC) Program Plan. Current rates for Type Service Codes listed above are presented in P359, Appendix A.

2) Cook County Private Agency Traditional Foster Care Performance Contract (PCC)

Type Service Code		Document
2102	Board Payment to the Foster Family: **Always use this Type Service Code for 906 Entry of new placements in Private Agency traditional foster homes.**	CFS 906-1
2902	Monthly board rate for licensed foster homes.	CFS 906-1
2602	Monthly support payment paid directly by DCFS to foster homes that are not licensed.	CFS 906-1
2191	Estimated monthly board payment prepared by the Department's Division of Budget and Finance.	C-13
2198/2298	Payment to Private Agency for Administration of Foster Care Cases prepared by the Department's Division of Budget and Finance.	C-13
2127	Assessment fee paid when the Department requests or approves an agency request for a special assessment because of an incomplete file or casework record.	CFS 1042
2401	Hourly rate for ongoing or extraordinary services such as reports, court appearances and services requested by the Department or required by the courts on behalf of children remaining at home.	CFS 1042
3033	Reunification casework services fee for children returned home.	CFS 1042
3034	Grant payment for reunification services, other than casework, based upon a detailed budget.	CFS 1042 & CFS 968-54

Instructions: The Division of Budget and Finance prepares the payment vouchers for Type Service Codes 2191 and 2198/2298. The private agency is responsible for initiating requests for payment related to all other Type Service Codes. All board payments for traditional foster homes are initiated by the private agency using the CFS 906-1, Type Service Code number 2102. The DCFS Central Office Client Payment Unit identifies the correct service type code and rate based upon the information in MARS/CYCIS. For additional explanation of services and payments, refer to the Cook County Private Agency Combined Traditional and Relative Foster Care Performance Contract Program Plan (PCC). Current rates for Type Service Codes listed above are presented in P359, Appendix A.

DEPARTMENT OF CHILDREN AND FAMILY SERVICES

Distribution: X and Z

POLICY GUIDE 2002.16

SUPPLEMENTAL SECURITY INCOME (SSI) SPECIAL NEEDS ALLOWANCE

RELEASE DATE: November 14, 2002

TO: Department and Purchase of Service (POS) Agency Permanency Staff and Rules and Procedures Bookholders

FROM: Jess McDonald

EFFECTIVE: Immediately

I. PURPOSE

The purpose of this Policy Guide is to advise staff of the Special Needs Allowances that will periodically be paid to relatives for children who are receiving federal Supplemental Security Income (SSI). This process was initiated effective July 1, 2002.

II. DISTRIBUTION OF SPECIAL NEEDS ALLOWANCE

Each month, the Children's Account Unit (CAU) will evaluate every unlicensed relative placement to determine which children are receiving SSI.

For children who are newly receiving SSI and are placed in unlicensed relative care, a SSI Special Needs Allowance will be initiated in the first month SSI payments are received.

For children who are currently receiving SSI and are placed in unlicensed relative care, a SSI Special Needs Allowance will be initiated whenever the child's account balance exceeds $750.00.

The amount of the SSI special needs allowance will be the difference between the standard of need rate and the licensed foster care rate, based on the age of the child. For DCFS and POS cases, allowance payments will be made through a special service fee. All of these payments will be paid directly to the caregiver.

III. USE OF ALLOWANCE AND REPORTING

Relatives are instructed to spend the allowance of the child's current maintenance needs on other services that may be needed because of the child's disability. Following is a brief description of the items/services for which the funds may be used:

- Personal allowance
- Clothing needs
- Personal needs related to the disability
- Tutoring, dancing lessons, art classes
- Education or job skills training
- Bus passes or other transportation needs
- Special foods for children with dietary needs
- Computers and educational software, which MUST move with the child
- Special Equipment needed to adapt to the child's disability, which MUST move with the child

Workers will need to complete the attached CFS 2023, Special Needs Allowance Utilization Form, prior to each Administrative Case Review to verify that the funds are being spent in accordance with their intent. The original CFS 2023 is to be forwarded to:

Children's Account Unit
406 East Monroe Street, Station 410
Springfield, IL 62701

A copy of the CFS 2023 is to be retained in the child's case file.

If it is determined the SSI Special Needs Allowance was not spent appropriately for the child, the allowance will cease and the caregiver will be asked to return the money to the Department.

IV. TERMINATION OF ALLOWANCE

The caregiver and case manager will receive notice when the SSI Special Needs Allowance will be terminated when:

- the foster parent becomes a licensed foster home; or
- other services are paid related to the child's specific disability that meet the child's special needs and the account balance drops below $750.00; or
- the account balance drops below $750.00; or
- the relative is unable to verify that funds were appropriately spent on the child; or
- the SSI benefit is terminated and the account is depleted.

V. QUESTIONS

Questions regarding this Policy Guide should be directed to Jodi Biggs at 217-785-2480.

VI. ATTACHMENTS

CFS 2023, Special Needs Allowance Utilization Form, which can be ordered from stores in the usually matter. The form is also available on the Department website and as a template on the SACWIS T drive.

Sample copy of the letter to Caregiver to Explain Allowance

Sample copy of the letter to Caregiver Terminating Allowance

VII. FILING INSTRUCTIONS

File this Policy Guide immediately following yellow page procedure 359.40 – 359.46 (4).

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3) Cook Small Agency Performance Contracts (PCS)

Type Service Code		Document
0140	Board Payment to the Foster Family: **Always use this Type of Service Code for 906 Entry of new placements in HMR foster homes.**	CFS 906-1
4140	Monthly rate for licensed relative homes.	CFS 906-1
3640	Monthly standard of need rate for unlicensed relatives.	CFS 906-1
0102	Board Payment to the Foster Family: **Always use this Type of Service Code for 906 Entry of new placements in Private Agency traditional foster homes.**	CFS 906-1
4102	Monthly rate for licensed traditional foster care homes.	CFS 906-1
3602	Monthly rate for unlicensed traditional foster care homes.	CFS 906-1
6187/6188	Administrative rate for foster care.	
0191	Estimated monthly payment prepared by the Department Division of Budget and Finance.	C-13
2127	Assessment fee paid when the Department requests or approves an agency request for a special assessment because of an incomplete file or casework record.	CFS 1042
2401	Hourly rate for ongoing or extraordinary services such as reports, court appearances and services requested by the Department or required by the courts on behalf of children remaining at home.	CFS 1042
3033	Reunification casework services fee for children returned home.	CFS 1042
3034	Grant payment for reunification services, other than casework, based upon a detailed budget.	CFS 1042 & CFS 968-54

Instructions: The Division of Budget and Finance prepares the payment vouchers for Type Service Codes 6187, 6188 and 0191, if applicable. In most cases, agencies providing services to children under this type of contract do not receive an estimated monthly payment. The Private Agency is responsible for initiating requests for payment related to all other Type of Service codes. All board payments for HMR foster homes are initiated by the private agency using the CFS 906-1, Type Service Code number 0140. For traditional foster care placements, use Type Service Code 0102. The DCFS Central Office Client Payment Unit identifies the correct type service code and rate based upon the information in MARS/CYCIS. When a child is placed in an unlicensed HMR foster home, the agency will receive payment for administrative services only, using type of Service code 6187 or 6188. For additional explanation of services and payments, refer to Attachment 3 of the Cook County Relative and Traditional Foster Care Program Plan, CFS 968-(PCS). Current rates for Type of Service Codes listed above are presented in P359, Appendix A.

Downstate Performance Contracts (PCD)

Type Service Code		Document
0140	Board Payment to the Foster Family: **Always use this Type of Service Code for 906 Entry of new placements in HMR foster homes.**	CFS 1042
9140	Monthly rate for licensed relative homes.	CFS 906-1
6140	Monthly standard of need rate for unlicensed relatives.	CFS 906-1
0102	Board Payment to the Foster Family: **Always use this Type of Service Code for 906 Entry of new placements in Private Agency traditional foster homes.**	CFS 906-1
9102	Monthly rate for licensed traditional foster care homes.	CFS 906-1
6102	Monthly rate for unlicensed traditional foster care homes.	CFS 906-1
6198/6191	Administrative rate for foster care.	C-13
0191	Estimated monthly payment prepared by the Department Division of Budget and Finance.	C-13
2127	Assessment fee paid when the Department requests or approves an agency request for a special assessment because of an incomplete file or casework record.	CFS 1042
2401	Hourly rate for ongoing or extraordinary services such as reports, court appearances and services requested by the Department or required by the courts on behalf of children remaining at home.	CFS 1042
3033	Reunification casework services fee for children returned home.	CFS 1042
3034	Grant payment for reunification services, other than casework, based upon a detailed budget.	CFS 1042 & CFS 968-54

Instructions: The Division of Budget and Finance prepares the payment vouchers for Type Service Codes 6191, 6198 and 0191, if applicable. In most cases, agencies providing services to children under this type of contract do not receive an estimated monthly payment. The Private Agency is responsible for initiating requests for payment related to all other Type of Service codes. All board payments for HMR foster homes are initiated by the private agency using the CFS 906-1, Type Service Code number 0140. For traditional foster care placements, use Type Service Code 0102. The DCFS Central Office Client Payment Unit identifies the correct type service code and rate based upon the information in MARS/CYCIS. When a child is placed in an unlicensed HMR foster home, the agency will receive payment for administrative services only, using Type of Service code 6198 or 6191. For additional explanation of services and payments, refer to Attachment 3 of the Downstate Private Agency Performance Contract Program Plan, CFS 968 (PCD). Current rates for Type of Service Codes listed above are presented in P359, Appendix A.

d) Agency Specialized Foster Homes

Type Service Code		Document
0109	Agency Specialized Foster Care–Open to Intake Contracts	CFS 906-1
0143	Agency Specialized Foster Care–Closed to Intake Contracts	CFS 906-1
0117	Intermittent Specialized Foster Care (See instructions below)	CFS 932
0124	Agency Foster Care (Non-Board)	C-13
0125	Specialized Foster Care (Non-Board)	C-13
0169	Agency Home of Relative Specialized Foster Care HIV	CFS 906-1
0179	Home of Relative Department Specialized Foster Care HIV	CFS 906-1
7109	Medicaid Agency Specialized Foster Care – Open for Intake Contracts	CFS 906-1

Instructions: Payment of the specialized rate is effective the date of movement into the specialized contract with the approval from the Specialized Foster Care Gatekeeper and/or the Child and Youth Investment Team (CAYIT). Upon approval by the Specialized Foster Care Gatekeeper and/or CAYIT, the children with physical, developmental, mental or behavioral impairments or conditions* may be placed with licensed foster parents supervised by licensed child welfare agencies. Children may be placed with Department licensed, supervised foster homes only by exception, beginning effective May 2, 2002:

*Written documentation of the impairment or condition must be in the child's case record.

Payment may be made using Type Service Code 0117 for weekend visits or vacations for children placed in specialized foster care from state-funded facilities (IDHS) which receive a clothing allowance for the child or for respite care for foster parents. See P359.45 (f) of these procedures.

e) Agency Foster Care – Non-Standard Rate

Type Service Code		Document
0909	Foster Care Program – Exempt from Specialized Foster Care Procedures	CFS 906-1

Instructions: Unique programs that pay a non-standard foster care rate, but are not classified as specialized foster care programs. Criteria for placement into these programs is defined in the program plan of each individual contract. Placement into Adolescent Foster Care (AFC) programs must have Specialized Gatekeeper approval prior to placement.

f) Intensive Service Foster Care

Type Service Code		Document
0103	Intensive Foster Care (No new placements eff. July 1, 2001) (See Appendix A (I)(b) for amounts)	CFS 906
0117	Intermittent Specialized Foster Care	CFS 932
0122	Intensive Foster Care	C-13

Instructions: Payments may be made to DCFS-supervised homes upon approval of the CFS 418 form required for children with specialized needs due to physical, developmental, mental or behavioral impairments or conditions. (Written documentation of the impairment or condition must be in the child's case record.) Children will not be placed in Department intensive foster care effective July 1, 2001.

Payment may be made using Type Service Code 0117 for weekend visits or vacations for children placed in Intensive Service care from state-funded facilities (IDHS) which receive a clothing allowance for the child, or for respite care for foster parents. (See P359.45(f) of these procedures).

g) Department Specialized Foster Homes

Type Service Code		Document
0114	Department Specialized Foster Care (Only for exceptions granted after May 2, 2002)	CFS 906
0144	Department Specialized Foster Care (No new placements effective May 2, 2002)	CFS 906

Instructions: Payments for children with specialized needs due to physical, developmental, mental or behavioral impairments or conditions will be made upon approval by the Child and Youth Investment Team (CAYIT) (Written documentation of the impairment or condition must be in the child's case record.) Effective May 2, 2002, children with specialized needs may not be placed in a Department supervised foster home unless by exception through the Specialized Foster Care Gatekeeper and / or the Child and Youth Investment Team.

h) Emergency Homes

Type Service Code		Document
0104	Emergency Foster Care (See Appendix A (I) (b) for amounts)	CFS 906
0117	Intermittent Specialized Foster Care	CFS 932
0123	Emergency Foster Care (Non-board)	C-13

Instructions: Placement in these homes is only for emergency reasons when family habilitation service is impractical or when neglect, abuse or family crisis necessitates immediate placement. Length of stay shall be no longer than 30 days at which time

payment will automatically stop. No later than 30 days after placement, the Regional Office is responsible for placing the child in a more permanent setting and starting payment in another Type Service Code. Another form CFS 906 must be completed to show the change in placement. Payment will be made only for those days the child is actually in the emergency placement.

Payment may be made using Type Service Code 0117 for weekend visits or vacations for children placed in emergency foster care from state-funded facilities (IDHS) which receive a clothing allowance for children or for respite care for foster parents. (See P359.45(f) of these procedures.)

i) Foster Care - Social Service Only

Type Service Code		Document
0118	Foster Care - Social Service only	CFS 1042
2118	Foster Care - Social Service Cook Count Performance Based Contract only	CFS 1042

Instructions: Payment may be made to private agencies or individuals for the delivery of specifically identified social services (except aftercare or reunification). Payment for room and board is made to the primary foster care provider. The rate is negotiated by contract or policy.

j) Deaf Foster Care

Type Service Code		Document
0105	Deaf Foster Care	CFS 906

Instructions: Board payments may be made for hearing impaired children for whom DCFS is not legally responsible but for whom DCFS arranged foster care placement due to the child's educational needs. See Rules 301.90 and Procedures 302.390 for explanation of services to hearing impaired children. The rate, see Appendix A for amounts, is based on a 5-day school week. An additional $25 per month is allowed if full time foster care is provided. Payments should stop at the end of school year. Note: The child's parents are responsible for providing clothing, medical, laundry and all personal expenses for their child in addition to paying the boarding home parents for necessary extra services they may request.

k) Special Service Fees

Type Service Code		Document
0019	SSI Special Needs Allowance	Central Office Entry
0020	Monitoring Phone Line Fee – Foster Care	CFS 906-4
0113	Special Service Fee - Foster Care	CFS 906-4
0129	Special Service Fee-Ward with Infant – Caregiver Expense	CFS 906-4
0138	Special Service Fee - Ward with Infant - Ward Expense	CFS 906-4
0146	Sibling Visitation Fee - Overnight	CFS 906-4

0157	Family Reunification Services (No new requests granted effective 12/01/04)	CFS 906-4
0165	Transportation Sibling Visitation Fee	CFS 906-4
0176	Supervision of Sibling Visitation Fee - Daytime	CFS 906-4
0200	Step-down rate – Specialized Foster Care	Central Office Entry
0307	Adoption Assistance – (When the adoption assistance agreement was submitted to the family prior to 11/28/95 only)	CFS 906-4

Instructions: See Appendix A for Special Fee amounts. Ward with infant, sibling visitation fees and monitoring phone line fee may be approved for children with any Type Service Codes. All other Special Service Fees may be approved for children with Type Service Codes 2102, 2140, 0101, 0102, 0103, 0106, 0107, 0115, 0122, 0140, 0151, 0152, 0153 and 0154 when these children require extraordinary expenses. When a special service fee is given to a private agency, the extra money must go to the foster parents, and must be so indicated in the service plan (CFS 497, Part II).

The Reason Codes that must be entered into the **CFS 906-4, Special Service Fee and Payment Extension Form** are:

Reason Codes	01	Child Behavior Problem
	02	Child Physical Problem
	03	Unusual Transportation
	04	Other
	05	Ward with Child – Caregiver Expenses
	06	Family Case Management
	07	Sibling Visitation - Overnight
	10	Ward with Child Home of Relative (Central Office use only)
	11	Ward with Infant - Ward Expenses (Central Office use only)
	14	Step-down rate – Specialized Foster Care (Central Office use only)
	15	Supervision of Sibling Visits - Daytime
	16	Transportation to/from Sibling Visits
	17	Family Reunification Services (No new requests granted effective 12/01/04)
	19	SSI Special Needs Allowance (Central Office use only)
	20	Monitoring Phone Line

The only acceptable expenses for special service fees are:

1) 0019 – SSI Special Needs Allowance — Reason Code 19

Instructions: A special service fee is initiated by Central Office upon notification from the Children's Account Unit of a placement of a child receiving SSI in an unlicensed relative home. The amount of the SSI special needs allowance will be

DEPARTMENT OF CHILDREN AND FAMILY SERVICES

Distribution: X and Z

POLICY GUIDE 2003.12

TYPE SERVICE CODE 0118 CASE MANAGEMENT ONLY SERVICES

DATE: December 1, 2003

TO: All DCFS and Purchase of Service Agency Child Welfare Staff and All Rules and Procedures Bookholders

FROM: Bryan Samuels, Director

EFFECTIVE: December 1, 2003

I. PURPOSE

The purposes of this Policy Guide are to clarify the circumstances under which the Department will approve and make payment to a Purchase of Service (POS) agency for Case Management Only Services (Type of Service Code 0118) and to replace Policy Guide 2002.15. Children placed in Independent Living situations and Transitional Living Programs (TLP) are covered by the Bed Hold Payments When Children are Absent from a Living Arrangement Policy Guide.

II. PRIMARY USERS

The primary users of this Policy Guide are DCFS and POS agency child welfare staff, DCFS regional contract staff, and DCFS financial payment staff.

III. PAYMENT OF CASE MANAGEMENT ONLY SERVICES (Type of Service Code 0118)

The Department of Children and Family Services only pays one agency at a time to provide case management services to a child for whom the agency is assigned case management responsibility. A case management only payment ($413.58 to a maximum of $516.98 depending on type of contract under which a child is being served) may be authorized to a private agency. The case management payment should be billed on a **CFS 1042, Billing Summary,** using Type of Service Code 0118.

Children placed in residential care, a group home, Transitional Living, or Independent Living programs are **not** covered by this Policy Guide. Existing Department policy and procedures governing the request and approval of bed holds should be followed for these types of placements.

The situations in which a case management payment may be authorized are as follows:

a) A child receiving specialized services who is placed with a caregiver who is receiving specialized payments directly from the Department (0114/0144 type service code) - The case management payment would be $516.98 prorated on a daily basis. **Inclusion of this situation is intended primarily to address current arrangements. The Department expects in the future a limited number of situations in which a child receiving specialized services is placed with a caregiver who is receiving specialized payments directly from the Department and case management is assigned to a POS agency.**

b) A child absent from placement for reason of "whereabouts unknown" or "abduction", who previously was in foster care assigned to a POS agency in a Downstate Performance Contract, Small Cook County Performance Contract, or Specialized Contract - Payment may be authorized for a maximum of 90 consecutive days, beginning the effective date of the absence from placement as entered on the **CFS 906-1, Placement/Payment Authorization,** at the applicable payment amount in note #1 based on the contract in which the child was being served prior to the absence from placement. The agency will continue aggressive efforts to locate the child under DCFS **Procedures 329, Locating and Returning Missing, Runaway and Abducted Children and reporting to the Child Location Unit within an hour.** Once located, even if beyond 90 days, the child will be assessed to determine if it's in the child's best interest to return to that agency.

c) A child hospitalized for medical reasons who, prior to hospitalization, was served in foster care assigned to a POS agency in a Downstate Performance Contract, Small Cook County Performance Contract or Specialized Contract - Payment may be authorized for all days of the hospital stay, beginning the effective date of the hospitalization as entered on the **CFS 906-1** at the applicable payment amount in note # 1 based on the contract in which the child was being served prior to the child's admission to the hospital.

d) A child in a county – operated juvenile detention facility, a jail or committed to the Illinois Department of Corrections for less than 90 days who previously was in foster care assigned to an agency in a Downstate Performance Contract, Small Cook County Performance Contract or Specialized Contract - Payment may be authorized for all days of the detention stay up to 90 days, beginning with the effective date of the detention as entered on the **CFS 906-1** at the applicable payment amount in note # 1 in which the child was being served prior to the child's placement in detention.

e) A child sentenced in a county-operated juvenile detention facility, a jail or committed to the Illinois Department of Corrections more than 90 days who previously was in foster care assigned to an agency in a Downstate Performance Contract, Small Cook County Performance Contract, or Specialized Contract - The child should be transferred back to the Department and payment will not be authorized for any days beyond 90. The POS agency must submit a copy of the **CFS 1425** with the **CFS 1042** to the Central Office Client Payment Unit (CPU),

which demonstrates notification of transfer to the Department has occurred. The CPU will notify the appropriate Downstate APT Supervisor or the Division of Monitoring/Quality Assurance when CYCIS reflects that a case has not been transferred back to the appropriate DCFS region according to the protocol described.

f) A child admitted to a hospital for psychiatric reasons and the child was served prior to admission in foster care by a POS agency in a Downstate Performance Contract, Small Cook County Performance Contract or Specialized Contract - Payment may be authorized for a maximum of 30 consecutive days, beginning the effective date of the psychiatric hospitalization as entered on the **CFS 906-1** at the applicable payment amount in note #1 for the contract in which the child was being served prior to the child's admission to the hospital. The child's case will NOT be transferred back to the Department even if the hospitalization is beyond 30 days.

g) A child admitted to a short-term residential drug or alcohol treatment facility who was served prior to admission in foster care by a POS agency in a Downstate Performance Contract, Small Cook County Performance Contract, or Specialized Contract - Payment may be authorized for a child in drug or alcohol treatment for a maximum of 90 consecutive days and the POS agency will maintain case responsibility, beginning the effective date of the short-term residential drug or alcohol treatment placement as entered on the **CFS 906-1** at the applicable payment amount in note # 1 for the contract in which the child was being served prior to the child's admission to the drug or alcohol treatment facility. The reason for placement "SAB" (child was placed in this setting because of his or her abuse of alcohol or drugs) should be used on the **CFS 906** when children are placed in these types of living arrangements.

If the drug or alcohol treatment stay is for more than 90 consecutive days, the child's case should be transferred to the appropriate DCFS region. The POS agency shall retain case management responsibility until the case is transferred to the Department. The POS agency must submit a copy of the **CFS 1425** with the **CFS 1042** to the Central Office Client Payment Unit (CPU), which demonstrates notification of transfer to the Department has occurred. The CPU will notify the appropriate Downstate APT Supervisor or the Division of Monitoring/Quality Assurance when CYCIS reflects that a case has not been transferred back to the appropriate DCFS region according to the protocol described. The POS agency will be compensated for case management until the Department accepts the transfer.

h) Child in a foster home where the foster parents have requested no monthly foster care payments: payment to the POS agency should be authorized at a maximum rate of $413.58 per month prorated on a daily basis if the child is served in a Cook County contract or $516.98 per month prorated on a daily basis if the child is served under a downstate contract.

i) A youth 18 and over that has selected their own placement (see **Procedures 301.60(d), Self-Selected Placements**), should be transferred back to the Department with a current **CFS 497, Client Service Plan**, for emancipation of the youth and the status of the plan. Additionally, if the youth has a court hearing or Administrative Case Review (ACR) scheduled within 30 days of the case transfer, both the transferring worker and the receiving worker shall attend the court hearing and/or the ACR. The POS agency shall retain case management responsibility until the case is transferred to the Department. Payment may be authorized for all of the days of case management prior to the date on which the case is actually transferred in CYCIS at a maximum rate of $413.58 per month prorated on a daily basis. The POS agency must submit a copy of the **CFS 1425** with the **CFS 1042** to the Central Office Client Payment Unit (CPU) which demonstrates notification of transfer to the Department has occurred. The CPU will notify the appropriate Downstate APT Supervisor or the Division of Monitoring/Quality Assurance when CYCIS reflects that a case has not been transferred back to the appropriate DCFS region according to the protocol described.

Note # 1: Following is a listing of the monthly rates that will be used to determine the per diem payment for "case management only" under each of the listed types of contracts. These rates are subject to change if the contract rate changes in any given fiscal year:

Specialized Care Contracts	$516.98
Small Cook County Contract (PCS)	$413.58
Downstate Performance Contract (PCD)	$516.98

Case Management Only services (Type of Service 0118) will **NOT** be approved for a child served under a Cook County Relative/Traditional Performance contract in any of the situations described above as the BAFC payment includes payment for case management services in the above described situations.

Note #2: A child admitted and sentenced for more than 90 days to the Illinois Department of Corrections (IDOC) and placed in an IDOC juvenile or adult correctional facility who previously was in foster care assigned to an agency in their Downstate Performance Contract, Small Cook County Performance Contract, Specialized Contract, Independent Living Contract or Transitional Living Contract should be transferred to the appropriate DCFS region immediately and will not receive any reimbursement.

Note #3: Availability of case management only services (type service code 0118) for youth participating in the Youth in College Program, the Scholarship program, the Youth in Employment or the Youth in Vocation program will be clarified at a later date. The agency should immediately initiate steps to transfer the child's case to DCFS.

IV. EXCEPTIONS

Payment for exceptions to this Policy Guide will be considered if appropriate documentation of the reason for the exception is sent to the Central Office Client Payment Unit.

V. BILLING PROCEDURES

Approval and entry of valid 0118 bills should follow this process:

a) The regional contract office receives a **CFS 1042** billing from the provider. The region determines that the bill is a valid bill and that the services listed have been delivered. The appropriate staff sign off on the billing as receiving officer.

b) The regional staff attaches a cover sheet to the **CFS 1042** indicating the name, address and phone number of the regional staff person to be contacted with any questions regarding the billing.

c) The regional office staff sends the billing to Central Office Client Payment Unit (CPU), Department of Children and Family Services, 406 East Monroe Street – Station #438, Springfield, Illinois 62701 for further review of the billings.

d) The Central Office Client Payment Unit approves or denies the bill.

1) Approved – CPU initials the bill (partial or entire) and verifies that the 0118 type service code and rate is in the provider's contract. If not, CPU notifies the Office of Contract Administration (OCA) to complete the process for adding the need for the rate to be included in the appropriate contract.

2) Denied – CPU sends the bill (partial or entire) back to the region with notification regarding the reason for denial.

e) OCA completes entry of rates and funding to the appropriate contract and notifies CPU when completed. CPU forwards the **CFS 1042** billings to the Client Payment Vouchering Unit for entry.

f) The Client Payment Vouchering Unit submits the bill to the Audit and Approval Unit for final auditing and approval. The Audit and Approval Unit will review the billing for the Client Payment Unit initials. If not initialed, the billing will be rejected back to CPU for review.

g) Approved billings will be processed to the Comptroller's Office for payment.

VI. QUESTIONS

Questions about this Policy Guide should be directed by telephone to the Department's Central Office Payment Unit in Springfield at 217-782-7043 or by fax at 217-557-0639.

VII. FILING INSTRUCTIONS

Remove Policy Guide 2002.15 in its entirety from behind Procedures 359.40 – 359.46 (10) and replace with this Policy Guide.

the difference between the standard of need rate and the licensed foster care rate, based on the age of the child. Relatives are instructed to spend the allowance on the child's current maintenance needs or other services that may be needed because of the child's disability. Workers must complete a CFS 2023, Special Needs Allowance Utilization Form, prior to each Administrative Case Review to verify the proper use of the funds. (See Policy Guide 2002.16)

2) 0020 – Monitoring Phone Line Reason Code 20

Instructions: A special service fee may be authorized to reimburse foster parents or relative foster parents for the expense of installing an additional dedicated phone line and monthly service fee of the line required for home monitoring of wards on probation. The special service fee may be requested on a CFS 906-4 by the worker and approved by the DCFS or POS supervisor. Payments may not exceed the maximum amounts indicated in Appendix A. A copy of the monthly telephone bill for the expense must be submitted with the CFS 906-4, and retained in the case file. The special service fee is valid for six months and may be renewed thereafter based on the length of probation.

3) 0113 - school needs which are not payable through Type Service Code 1401 or family visiting needs that are not payable through Type Service Code 1407.

4) 0113 - diet related to medical needs if not covered by the Department of Health and Family Services (DHFS).

5) 0113 - expenses related to special care based on the physical, mental and emotional problem/handicap or condition of the child.

6) 0129* – Ward with Infant – Caregiver Expenses. This special service fee initiated by the worker is to be used when a foster parent incurs extraordinary expenses related to the costs of caring for a ward's child. The ward must be the full time custodial parent.

This service fee is not based on the number of children. The foster parent can receive up to the maximum per ward with children. For example, if the maximum is $149 per month up to six months, and the foster parent has one parenting ward with three children, the foster parent can receive up to $149 per month for the six months. Conversely, if the foster parent has two wards each with one child, the foster parent can receive up to $149 per month, per ward.

7) 0138* – Ward with Infant – Ward Expenses (Central Office only)

Instructions: This special service fee is initiated by Central Office (217/524-1974) after a worker notifies Central Office of a parenting ward with children who reside with the ward. It is to be used by the ward for the care of her/his child. The ward must be the full time custodial parent. This special service fee is based

on the number of children living with the ward. For example, if the ward has two children, this special service fee will be $204 per month. The 0138 special service fee is the ward's money. When a ward is unable to manage his/own money, the foster parent may assist in the management of the 0138 special service fee funds. The goal is to train the ward to manage the money and care for the child.

***NOTE**: For both codes 0129 and 0138, these special fees are not to be issued unless the ward is the full time custodial caregiver. If the Department takes legal custody of the ward's child, the special service fees cease. The 0129 service fee is not ongoing like the 0138. It is to be used for extraordinary expenses incurred by the foster parent as a result of the caring for a parenting ward. The 0129 special service fee is not to exceed six months.

8) 0146 - Sibling Visitation Fee - Overnight Reason Code 07

Instructions: A special service fee, see Appendix A (I)(b) for amounts, per month that may be paid to the foster parents for hosting an overnight visit for the brother(s) and sister(s) of the child(ren) in their care. The payment is to be made under the child's ID of the oldest sibling who is placed in the hosting foster parent's home. The visit must be overnight or longer. The start date will be the day the visit began and the stop date will be the day the visit ended. The fee amount must be indicated to reflect sibling visitation. The CFS 315, Sibling Visitation Form will serve as documentation for the sibling visitation special service fee and should be filed in the case record in the same manner as the special service fee/payment extension form CFS 906-4. Supervision of daytime sibling visits is paid with Service Code 0176, which excludes overnight visits. See description in 359.40 (k)(10) below.

9) 0165 Sibling Visitation Transportation Only Reason Code 16

Instructions: A special service fee may be authorized to reimburse foster parents and relative foster parents to support sibling visitation through transportation. The worker may request to reimburse the foster parent for transportation costs up to the amount specified in Appendix A (I)(b) at the CMS travel guidelines rate or for the cost of public transportation, bus or taxi fare. The special service fee may be requested by the worker and approved by the DCFS or POS supervisor based on a visitation plan that is developed by the worker and the foster parent (and any child over age 7). Documentation of the transportation costs should be filed in the case record with the CFS 315 and CFS 906-4.

10) 0176 - Sibling Visitation Supervision Only–Daytime Reason Code 15

Instructions: A special service fee may be authorized to reimburse foster parents and relative foster parents to support sibling visitation through supervision. The supervision of sibling visitations is to be done at times other than the overnight visitation. The special service fee may be requested by the worker and approved

by the DCFS or POS supervisor, based on a visitation plan that is developed by the worker and the foster parent (and any child over age 7). The CFS 315 will serve as documentation for the sibling visitation-supervision only special service fee and should be filed in the case record in the same manner as the special service fee/payment extension form CFS 906-4. This special service fee is valid for six months and may be renewed thereafter pursuant to an updated visiting plan and approval of the DCFS or POS supervisor.

The caseworker may request a special service fee to reimburse the child's foster parent or other foster parent for planned supervision of the visits other than overnight visits at a rate indicated in Appendix A (I) (b) (excluding travel time) for a maximum of 4 hours each month. If visits for which a payment is made do not occur, the Department will seek reimbursement from the caregiver per Rule and Procedures 359.100, Overpayments and Repayments.

11) 0200 – Step down rate, Specialized Foster Care Reason Code 14

Instructions: A special service fee may be entered by Central Office to enhance the amount paid to the foster home for a child who has been determined to have expenses related to the child's special needs that cannot be met through a contract or other Department sources. The determination of the child's specialized status must be completed by the CAYIT.

12) 0307 – Adoption Assistance Reason Code 04

Instructions: A special service fee for adoption assistance cases is allowable only for those adoptions for which adoption assistance agreements were presented to the families prior to November 28, 1995. Refer to Procedures 359, Section 359.42(c).

Documentation for Special Service Fees:

The necessary documentation explaining the need for the special service fee and justification for its use shall be written on the CFS 906-4 and a copy submitted to the Regional Administrator (or Supervisor in the case of Transportation and Supervision of Sibling Visits) for approval. Following approval, the worker shall place a copy in the child's case record.

Termination or Renewal of Special Service Fees:

The Special Service Fee is to be discontinued upon termination of the specific need. Special service fees are automatically suspended at the end of six months and must be reviewed by the approval source; Regional Administrator, Cook County designee, (or Supervisor in the case of Transportation and Supervision of Sibling Visits) after the first six months. The worker shall submit requests for renewals of special service fees 30 days prior to the date on which the payments will terminate in order for the fees to be renewed without disruption of payment.

Limitations on Payment:

Foster parents receiving reimbursement for intensive foster care, specialized foster care, or for emergency foster care cannot receive a special service fee under any circumstances except for sibling visitation, monitoring phone line, or ward with infant.

l) Client Assessments Performed by Private Agencies

Type Service Code		Document
0127	Case Assessment Fee	CFS 1042
2127	Case Assessment Fee – Performance Contracts	CFS 1042

Instructions: The Department's Chief of Staff must approve the private agency's eligibility to perform client assessments. When a caseworker wants to ask a private agency to perform client assessments, he/she must obtain the approval of his/her supervisor and refer the matter to the contract liaison. The region will prepare a C-13 after the private agency submits the client assessment, related forms, and the billing form CFS 1042, Billing Summary. See Appendix A(I)(b) for amounts.

Section 359.41 Payments for Residential Care

If the placement relates to any of the following placements: Institutional Residential Care, Child Welfare Group Homes, Transitional Living or Supervised Independent Living Substitute Care programs (see P. 359.60), the Agency must complete the CFS 906-1, Placement/Payment Authorization Form immediately after placement and then transmit the CFS 906-1 placement form information via telephone call to the appropriate Region. The appropriate Region must receive the call within two working days of the client's placement or discharge. If the CAYIT has not approved the placement, the payment will be entered as a "no pay" until the approval is submitted to the appropriate regional 906 office. Retroactive payments will not be authorized more than two days prior to the time the telephone call is received by the appropriate Region.

a) Child Care Institutions

Type Service Code		Document
0201	Private Institutions	CFS 906-1
0213	Private Institution	C-13
0209	Intermittent Contracted Institutional Care	CFS 932
7201	Medicaid Private Institution	CFS 906-1

Instructions: Institutions must be licensed childcare institutions under DCFS Contract (CFS 968-45).

b) Group Homes

Type Service Code:		Document
0203	Private Group Homes	CFS 906-1
0214	Private Group Homes	C-13

DEPARTMENT OF CHILDREN AND FAMILY SERVICES

POLICY GUIDE 2003.11

Distribution: X and Z

BED HOLD PAYMENTS WHEN CHILDREN ARE ABSENT FROM A LIVING ARRANGEMENT PLACEMENT

DATE: December 1, 2003

TO: All DCFS and Purchase of Service Agency Caseworkers, Supervisors, and Managers
All Purchase of Service Residential Care Providers
Independent Living Providers
Transitional Living Providers
All DCFS Financial Management Staff
All Rules and Procedures Bookholders

FROM: Bryan Samuels, Director

EFFECTIVE: December 1, 2003

I. PURPOSE

The purpose of this Policy Guide is to implement revised procedures governing the request and approval of bed holds when children who are placed in a living arrangement (institution, group home, transitional living program, or independent living arrangement) are absent from their usual living arrangement due to certain reasons specified in this Policy Guide.

Child Absences Covered by this Policy: Children covered by this policy include any child who is absent from his/her living arrangement due to: hospitalization for psychiatric or medical reasons; runaway; placement in a county-operated detention center; or admission to an inpatient alcohol or other drug abuse treatment program licensed by the Illinois Department of Human Services.

Compliance with Other Controlling Policy and Procedures: Nothing in this policy relieves a caseworker of her/his responsibilities described in any other Department policy or established procedures concerning children who are psychiatrically hospitalized and procedures concerning children who are thought to have run away, been abducted and/or are missing. These absences must be reported within an hour to the Child Location Unit. Also, caseworkers are responsible for promptly reporting a child's absence from and return to the child's placement by contacting the appropriate downstate regional 906 Hotline or the Cook County Case Assignment and Placement Unit (CAPU) as required by Department procedures.

Discharge of Children Who Are Absent from a Residential Care Placement: A provider of residential care services may unilaterally discharge a child who is absent from the residential care placement upon written notice to the assigned Department caseworker. The provider will be paid for the last day the child was present in the residential care placement when there is an approved bed hold episode in effect on the date the provider notifies the Department of the child's discharge from the residential care placement.

Additionally, a provider of residential care services who is determined by the Department to have a pattern of discharging children while children are absent from the placement may be subjected to a referral hold and/or an independent utilization review at the discretion of the Department.

II. PRIMARY USERS: The primary users of this Policy Guide are caseworkers assigned to children who are placed in residential care, a transitional living program, an independent living arrangement, and staff members of the residential care placement, transitional living program, and independent living arrangement from which children are absent.

III. Key Words

Approved bed hold day, approved bed hold episode, psychiatric hospitalization, alcohol or other drug treatment, runaway, whereabouts unknown, reimbursement rates

IV. Definitions

"Approved bed hold day" means a day during a child's absence on which the provider provided one or more services to or on behalf of the absent child **and** the day on which the service was provided is within the period for which a bed hold has been approved in compliance with these procedures.

"Approved bed hold episode" means a period of time that shall not exceed 30 consecutive days during which a child is absent from a living arrangement placement and for which the Department has approved payment to the provider for each day during the child's absence on which the provider provided one or more services to or on behalf of the child and documented the provision of the service in the child's treatment record. For the purpose of this Policy Guide, one approved bed hold episode may include a child experiencing more than one of the types of absences covered under the policy guide (e.g. runaway and detention) as long as the child does not return to the living arrangement placement at any time during the approved bed hold episode.

An approved bed hold episode begins on the date the child was first absent or two working days prior to the provider reporting the child's absence to the appropriate downstate regional 906 Hotline or the Case Assignment and Placement Unit (CAPU) in Cook County, which ever is later.

An approved bed hold episode ends when one of the following events occurs:

- The provider notifies the appropriate downstate regional 906 Hotline or the CAPU in Cook County that the child returned to the placement from which the child was absent; or
- The child does not return and the provider notifies the assigned caseworker the child has been discharged from the living arrangement; or
- The child returns but the assigned caseworker determines that it is not in the child's best interest to return to the living arrangement from which the child was absent.

Except as provided in Section VII, Exceptions, of this Policy Guide, an approved bed hold episode will be limited to a maximum of 30 consecutive days. The 30 days maximum begins on the date on which the child was first absent and ends 30 days later. However, payment for an approved bed hold episode that is approved pursuant to these procedures will begin on the date the child was first absent or two working days prior to the date on which the provider reported the child's absent to the appropriate downstate regional 906 Hotline or the CAPU in Cook County, **which ever is later** and end no later than 30 days after the date on which the child was first absent.

V. GENERAL REQUIREMENTS

A residential care, transitional living, or independent living provider must report a child's absence from and return to the living arrangement to the appropriate downstate regional 906 Hotline or the Cook County CAPU within 48 hours (two working days) after the day on which the child was first absent. If the provider does not comply with the 48 hour (two working days) notification and if a bed hold episode is subsequently approved, the provider will receive payment beginning 48 hours (two working days) prior to the date the provider notified the Department of the child's absence and ending on the last day of the approved bed hold episode or the date on which the child returns to the living arrangement, whichever is earlier. For example, the provider notifies the Department of a child's absence 4 days (96 hours) after the child was first absent and returned to the placement 40 days later. A bed hold episode is subsequently approved. The approved bed hold episode is a maximum of 30 days from the date on which the child is first absent from the program; however, payment for the approved bed hold episode would be for a maximum of 28 days, as long as the provider complies with all the requirements of this Policy Guide.

Except as explained in Section VII, Exceptions, of this Policy Guide, a child must return to the provider from which the child was absent as a condition of payment for an approved bed hold episode. Additionally, the provider will ONLY receive payment for a day during an approved bed hold episode on which the provider provided one or more services to or on behalf of the child and the provision of service is documented in the child's treatment record. Any day during an approved bed hold episode on which the provider provides NO service to or on behalf of the child will not be reimbursed.

All requests for bed hold payments must be submitted and approved on the **CFS 906-5**, **Bed Hold Payment Request**, that is an attachment to this Policy Guide.

VI. APPROVAL PROCEDURES

A. Staffing

Within 3 working days (72 hours) of the date on which a child is absent from her/his living arrangement because the child has run away, has been placed in detention by a judge, has been admitted to a hospital for psychiatric reasons, or has been hospitalized for medical reasons, there must be a case staffing involving, at a minimum, the Department or agency caseworker assigned to the child **or** the caseworker's supervisor, and a representative of the provider who is knowledgeable about the clinical needs of the child. The purpose of the staffing is to determine whether it is in the best interest of the child to return to the living arrangement when the child returns from the absence. The staffing must be documented by the caseworker or by the caseworker's supervisor on a **CFS 492, Case Entry** form or the appropriate contract case entry form and by the living arrangement provider in the child's treatment record.

If the case staffing does not occur within 3 working days, no bed hold payment will be made without the approval of the Deputy Director of the Division of Placement/Permanency or the Division of Field Operations.

B. Child Will Not Return to Previous Placement

If it is determined by the staffing that it is **not** in the child's best interest to return to the previous living arrangement, the provider shall complete the **CFS 906-5** to document services provided to or on behalf of the child on each day on which the child was absent and the assigned caseworker or the caseworker's supervisor will sign the **CFS 906-5**. The provider will fax the **CFS 906-5** to the Department's Central Office Client Payment Unit (CPU) at 217-557-0639. The CPU will compare the **CFS 906-5** data to CYCIS information concerning the date on which the child's absence was reported. The CPU will process a "**case management only"** payment in the amount of $ 19.04 per day for the dates on which the provider provided one or more services beginning on the date of the child's absence or 48 hours (two working days) prior to the provider reporting the child's absence, whichever is later, and ending on the date of the staffing at which it was determined that the child would NOT return to the previous living arrangement.

C. Child Will Return to Previous Placement

If it is determined by the staffing that it **is** in the best interest of a child to return from the absence to the previous placement, the following procedures apply:

1. If the child returns to the provider before the 72 hour staffing, the provider shall promptly notify the appropriate downstate regional 906 Hotline or the Cook County CAPU of the child's return. The provider shall also complete the **CFS 906-5** to document what service was provided to or on behalf of the child each day during the child's absence. The DCFS or agency caseworker and the caseworker's supervisor shall sign and date the **CFS 906-5**. The provider will fax the **CFS 906-5** to the Central Office Client Payment Unit (CPU) at 217-557-0639. The CPU will compare the **CFS 906-5** data to CYCIS information concerning the date on which the child's absence was reported. The CPU will process payment for the dates on which the provider provided one or more services beginning on the date of the child's absence or 48 hours (two working days) prior to the provider reporting the child's absence which ever is later and ending on the date that the child returned to the previous living arrangement.

2. If the child returns to the provider after the 72 hour staffing but before 30 consecutive days from the date on which the child was first absent, the provider shall promptly notify the appropriate downstate regional 906 Hotline or the Cook County CAPU of the child's return. The provider shall also complete the **CFS 906-5** to document what service was provided to or on behalf of the child each day during the child's absence. The assigned DCFS or agency caseworker and the caseworker's supervisor shall sign and date the **CFS 906-5**. The provider shall fax the **CFS 906-5** to the Central Office Client Payment Unit (CPU) at 217-557-0639. The CPU will compare the **CFS 906-5** data to CYCIS information concerning the respective dates on which the child's absence and return were reported. The CPU will process payment for the dates on which the provider provided one or more services beginning on the date of the child's absence or 48 hours (two working days) prior to the provider reporting the child's absence, whichever is later, and ending on the date that the child returned to the previous living arrangement.

VII. EXCEPTIONS

A. No Staffing Occurs (Only in cases in which DCFS holds case management responsibility)

If the assigned DCFS caseworker or the caseworker's supervisor fails to participate in the staffing required by these procedures, the residential care, transitional living, or independent living provider shall, upon the child's return, promptly notify the appropriate downstate regional 906 Hotline or the Cook CAPU of the child's return. The provider shall also complete the **CFS 906-5** to document what service was provided to or on behalf of the child each day during the child's absence. At the bottom of the form in the space for the caseworker's signature, the provider will write **"DCFS caseworker and supervisor were contacted about the staffing and failed to participate in the required staffing."** A representative of the provider will then sign and date the **CFS 906-5** in the space for the "supervisor's signature." A provider's submittal of the **CFS 906-5** in this circumstance is considered a statement of intent of the provider to accept the child back for care upon the child's return from the absence.

The provider shall fax the **CFS 906-5** to the Central Office Client Payment Unit (CPU) at 217-557-0639. CPU will compare the **CFS 906-5** data to CYCIS information concerning the respective dates on which the child's absence and return were reported. The CPU will process payment for the dates on which the provider provided one or more services beginning on the date of the absence or 48 hours (two working days) prior to the date the provider reported the child's absence, whichever is later, and ending on the date that the child returned to the previous living arrangement.

B. Consecutive Approved Bed Hold Episode

A consecutive bed hold episode may be approved by the Deputy Director of the Division of Placement/Permanency or the Deputy Director of the Division of Field Operations and only when a child is hospitalized for medical or psychiatric reasons or is detained in short-term incarceration (county operated detention facility), and:

1. the child will return to the previous provider; and

2. the child's discharge date is after the date on which the initial "approved bed hold episode" ends.

The assigned DCFS or agency caseworker's supervisor and the residential care, transitional living, or independent living provider must jointly request approval of a consecutive approved bed hold episode in writing via a decision memorandum to the Deputy Director of the Division of Placement/Permanency or the Deputy Director of the Division of Field Operations. The DCFS or agency supervisor and living arrangement provider must explain in detail why the consecutive approved bed hold episode is required and the date on which it is planned that the child will return to the previous placement.

The provider shall promptly notify the appropriate downstate regional 906 Hotline or the Cook County CAPU when the child returns to the previous living arrangement. The provider shall complete the **CFS 906-5** to document what service was provided to or on behalf of the child each day during the child's absence. The assigned DCFS or agency

caseworker and the caseworker's supervisor shall sign and date the **CFS 906-5**. The provider shall fax the **CFS 906-5 AND** a copy of the decision memo for the Deputy Director of the Division of Placement/Permanency or the Deputy Director of the Division of Field Operations to the Central Office Client Payment Unit (CPU) at 217-557-0639. The CPU will compare the **CFS 906-5** data to CYCIS information concerning the respective dates on which the child's absence and return were reported. CPU will forward the **CFS 906-5** and decision memo to the Deputy Director for approval. If approved, CPU will process payment for the dates on which the provider provided one or more services beginning the first day of the absence or 48 hours (two working days) prior to the date the provider reported the child's absence, whichever is later, and ending on the date that the child returned to the previous living arrangement.

C. Child Does Not Return to Previous Living Arrangement As Planned

If, based on the staffing required by these procedures, the intent was for a child to return to the previous living arrangement, but the supervisor of the assigned caseworker decides subsequently that it is NOT in the best interest of the child to return to the previous living arrangement, the supervisor shall, within one working day of the decision, notify the provider in writing that the child will not return to the placement. The date on the written notice will be the effective date of the child's discharge from the living arrangement placement. The Department will pay the provider under this bed hold policy each day of a documented service up to the notification date of the child's discharge from the living arrangement placement, not to exceed 30 days. Thereafter, if case management responsibility is retained by the living arrangement provider, the provider will need to request from the Department a **"case management only"** payment for each day the provider provided and documented one or more services to or on behalf of the child and remains the case manager of record**.** The provider shall complete the **CFS 906-5** to document what service was provided to or on behalf of the child each day during the child's absence. The assigned caseworker and the caseworker's supervisor shall sign and date the **CFS 906-5**. The provider shall fax the **CFS 906-5 AND a copy of the memorandum from the supervisor** to the Central Office Payment Unit (CPU) at 217-557-0639. The CPU will compare the **CFS 906-5** data to CYCIS information concerning the date on which the child's absence was reported. The CPU will process the different payments, if appropriate, for the dates on which the provider provided one or more services beginning on the first day of the child's absence or 48 hours (two working days) prior to the date the provider reported the child's absence, whichever is later, and ending on the date of the notice from the caseworker to the provider that the child would not return to the provider and/or remained the case manager of record.

VIII. REIMBURSEMENT RATES FOR APPROVED BED HOLD EPISODE

If an absent child **does** return to the previous placement, Medicaid-certified and non-Medicaid certified residential care providers will be reimbursed at the provider's established per diem rate for each day within an approved bed hold episode on which the provider provides one or more services to or on behalf of the absent child as documented in the child's treatment record and on the **CFS 906-5**.

If the child **does NOT** return to the previous living arrangement, the Department will pay the provider a "case management only" payment for each day during an approved bed hold episode that the provider provided one or more services to or on behalf of the absent child as documented in the child's treatment record and on the **CFS 906-5**.

IX. QUESTIONS

Questions about this Policy Guide should be directed to the Department's Central Payment Unit at 217-782-7043.

X. ATTACHMENTS

Attachment A - Frequently Asked Questions

CFS 906-5, Bed Hold Payment Request
These can be ordered in the usual manner. A template is also available on the T: Drive.

XI. FILING INSTRUCTIONS

Remove Policy Guide 2002.14 in its entirety from behind Procedures 359.40 – 359.46 (16) and replace with this Policy Guide.

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POLICY GUIDE 2003.11

BED HOLD PAYMENTS WHEN CHILDREN ARE ABSENT FROM A RESIDENTIAL CARE, A TRANSITIONAL LIVING, OR AN INDEPENDENT LIVING PLACEMENT

Attachment A – Frequently Asked Questions

1. Does the bed hold policy apply to foster care and Pregnant and Parenting Teen (PPT) programs?

- Foster care bed holds will be completed as in previous fiscal years through the completion of a **CFS 906-4, Special Service Fee and Extension** form, but it MUST be faxed to the CPU for entry. Formal policy of foster care bed holds will be forthcoming during this fiscal year.

- If a pregnant or parenting teen is in a residential, independent living, transitional living, or group home setting, the bed hold policy applies.

2. How does the bed hold policy apply to ILO/TLP Programs in light of the Department runaway protocols?

For the purpose of the bed hold policy and submittal of a **CFS 906**, a youth in ILO/TLP will be considered as continually in placement and not require special bed hold payment approval when absent from placement for 24 hours. The one hour guideline for initiating the runaway protocol should still be observed. If the child is absent for more than 24 hours, a CFS 906 should immediately be called in to the Case Assignment Placement Unit or the appropriate downstate regional 906 hotline effective the date of the run.

3. If the private agency attempts to perform a service, such as an off-site visit to a detention facility, and the ward refuses to see them, can they put that down as a service since they did actually go to the facility and were unable to visit?

Yes, as long as the agency documents the attempted contact in writing in the child's treatment record or on a **CFS 492, Case Entry** form. The **CFS 492** should NOT be sent with the **CFS 906-5** to the Central Office Client Payment Unit.

4. In the past, the private agency claim voucher included any paid bed hold days. How does a provider reflect on the claim voucher the bed hold that hasn't been approved or entered on the system yet?

In most cases an agency's claim voucher will be submitted to the Department prior to the bed hold being approved and entered. The agency should submit the claim without the bed hold days. The agency will be paid for the actual placement days until the bed hold goes on. The bed hold days will no longer be required to be a part of the claim voucher process. Submission of the **CFS 906-5** and subsequent approval replaces the claim voucher process.

5. What about a child who is absent from placement for reason of whereabouts unknown or abduction, the staffing occurs, and the intention is for the child to return to the same facility, but the child stays absent for an extended period of time (beyond 30 days). When should the agency send in its 906-5?

The **906-5** should be submitted once the child has returned to the facility.

If the child is absent due to hospitalization for medical or psychiatric reasons or detention more than 30 days from the initial date of absence, a consecutive bed hold episode must be approved by the Deputy Director of the Division of Placement/Permanency or the Deputy Director of the Division of Field Operations (See Sec. VII. B. of the Policy Guide).

6. What about a child who is absent from placement for reason of whereabouts unknown or abduction, the staffing occurs, and subsequently it is determined by the Department and the facility that the child will NOT be returned to the facility. When should the agency send in its 906-5?

The **906-5** should be submitted immediately upon the determination that the child will not be returned to the facility. There has to be verification/documentation that the Department and the facility have jointly agreed that the child will not be returned.

The **906-5** should contain the signature of the DCFS or agency case manager or supervisor along with a signed memo indicating the date the decision was made for the child not to return

7. What about a child who is absent from placement for reason of whereabouts unknown or abduction and the facility unilaterally decides that the child will be discharged. When should the agency send in its 906-5?

Payment for a bed hold will NOT be made when a facility unilaterally decides to discharge a child, therefore a **906-5** should not be submitted.

8. What if the service performed by the living arrangement staff doesn't fit into any of the services listed on 906-5.

The services listed on the **906-5** are Medicaid mental health services. When a non-Medicaid agency provides a service or when a Medicaid certified agency performs a non-Medicaid service, staff should choose the service that most closely reflects the task that was actually performed. If the task does not fit into the given services, call CPU at 1-800-525-0499 option 2.

9. If a youth returns to the facility within 72 hours and prior to the completion of a staffing, does a staffing with DCFS still need to occur?

Since the purpose of the staffing is to determine if it is in the child's best interest to return to the living arrangement and the child has already returned to the living arrangement, a staffing need not be held. Procedures for this situation are found in Sec. VI. Part C. (Child Will Return to Previous Placement) of this Policy Guide.

10. If a child is absent from placement for reasons of whereabouts unknown or abduction then returns in 25 hours, then leaves again for another 25 hours, how should this be reflected?

When a child is gone for less than 72 hours and a staffing has not occurred and the facility performed services for any of the days of absence beyond the required notifications of the run protocol found in Rule Part 329, a **906-5** must be submitted reflecting the services in order to receive payment. If the child returns to the facility and then is absent again, each incident will be treated as a separate discrete absence.

11. Are only business days counted when determining when the 72-hour staffing must occur?

The staffing must take place within three State of Illinois working days.

12. Does the facility fax the initial 906-5 to the Central Office Client Payment Unit (CPU) before the staffing has occurred, before services have been provided, or before the child has returned to the agency?

The **906-5** will always be faxed to CPU **after** the services have been provided and **after** the child has been returned to the agency. If it is determined that the child will not be returned to the agency through the staffing, then a **906-5** can be completed and faxed to CPU because that agency is finished providing services to the child/family.

The **906-5** should contain the signature of the DCFS or agency case manager or supervisor along with a memo that the child is not returning.

OR

The **906-5** should be submitted along with a copy of the written notice to the assigned DCFS case manager that they are discharging the child from the facility.

13, Can the facility fax a 72 hour staffing request to DCFS and will all DCFS staff agree to this? Or does the facility need to call to request the staffing?

The facility should contact the appropriate DCFS staff via telephone or email in order to schedule a staffing. The agency may also fax a request; however, an agency should not rely ONLY on faxing since a worker or supervisor may inadvertently not receive the request.

14. Can the facility set or suggest the staffing time or do DCFS and the facility have to agree on a time (which could place agencies over the 72 hour limit at no fault of their own)?

The facility can suggest a time for the staffing with DCFS, but the staffing will take place by mutual agreement. All parties should work together to ensure that the staffing takes place in a timely manner.

15. Will an agency be paid for a bed hold if there are not any services identified on the CFS 906-5 form when submitted to CPU?

An entry must be made for every day during which a service was performed. Only those days in which a service was performed are eligible for bed hold payments.

7203	Medicaid Private Group Home	CFS 906-1
0222	Emergency Shelter Group Home	CFS 906-1

Instructions: These Type Service Codes applies to those licensed facilities under DCFS Contract (CFS 968-45).

c) Other Institutions

Type Service Code		Document
0202	Other Institutions	CFS 906-1
0221	Emergency Shelter	CFS 906-1
7221	Medicaid Emergency Shelter	CFS 906-1

Instructions: "Other institutions" include specialized residential facilities, academies, shelter care and halfway houses, all of which must meet applicable licensing standards and have a DCFS contract.

d) Placement Prevention and Reduction

Type Service Code		Document
0211	Placement Prevention and Reduction	CFS 1042

Instructions: Provides services to maintain a child in his/her family thereby deterring the placement of the child in residential care. This is accomplished through the building of social, educational and emotional strengths within the family unit through the utilization of community resources. Payment may be made at an hourly or daily rate as established by contract.

Section 359.42 Payment for Adoption Assistance – Subsidized Adoptive Homes

Payment Documents

Use the CFS 906, Placement/Payment Authorization Form (Department Foster Care) for monthly adoption assistance, CFS 906-4, Special Service Fee and Payment Extension Form (use only to renew Special Service Fees authorized before November 28, 1995) and the CFS 932, Purchase Authorization Billing Statement for all other payments.

Instructions:

a) Basic Ongoing Monthly Adoption Assistance Payments

Ongoing monthly adoption assistance payments may be authorized following finalization of an adoption with adoption assistance. These payments are to be discontinued at age 18 (or 19 if the child is in school), unless the Department has determined that they should be continued until age 21 because the child has a physical, mental or emotional disability (the onset of which preceded the finalization of the adoption) that warrants the

continuation of assistance and the child is not eligible for sufficient other benefits. Eligibility for adoption assistance must be reviewed whenever the family or child's circumstances change but at least annually to determine whether the adoptive parent(s) remains legally and/or financially responsible for the child. The Type Service Codes and maximum amounts depend on the type of placement the child was in prior to the adoptive placement. The Type Service Codes are as follows:

Type Service Code	0331	Equal to the foster care board rate prior to July1, 2006

Instructions: Use this Type Service Code if the child resided in placements receiving the regular foster care board rate and is not eligible for other benefits (i.e. SSA, Veteran's, etc.). This code is used for adoption assistance cases for which the adoption assistance agreement was submitted to the family prior to July 1, 1995.

Type Service Code	0332	Equal to the foster care board rate for Adoptions effective prior to July 1, 2006 (See Appendix A (I) (c) for amounts)

Instructions: Use this Type Service Code if the child resided in placements receiving the regular foster care board rate and is not eligible for other benefits (i.e. SSA, Veteran's, etc.). This code is used for adoption assistance cases for which the adoption assistance agreement was submitted to the family after June 30, 1995.

Type Service Code	0346	Equal to the foster care board rate for Adoptions effective after June 30, 2006

Instructions: Use this Type Service Code if the child resided in placements receiving the regular foster care board rate. This code is used for adoption assistance cases for which the adoption was effective after June30, 2006.

Type Service Code	0317	Equal to the foster care board rate for Adoptions effective after September 30, 2008

Instructions: Use this Type Service Code if the child resided in placements receiving the regular foster care board rate. This code is used for adoption assistance cases for which the adoption was effective after September 30, 2008.

Type Service Code	0333	Equal to the intensive foster care rate on Adoptions effective prior to July 1, 2006

Instructions: Use this Type Service Code if the child resided in a foster family home receiving the intensive board rate or resided in a group home, institution or other residential placement and is not eligible for other benefits. This code is used for adoption assistance cases for which the adoption assistance agreement was submitted to the family prior to July 1, 1995.

Type Service Code	0334	Equal to the intensive foster care rate on adoptions effective prior to July 1, 2006 (See Appendix A (I) (c) for amounts)

Instructions: Use this Type Service Code if the child resided in a foster family home receiving the intensive board rate or resided in a group home, institution or other residential placement, and is not eligible for other benefits. This code is used for adoption assistance cases for which the adoption assistance agreement was submitted to the family after June 30, 1995.

Type Service Code	0336	Specialized Rate - Manually Entered

Instructions: Use this Type Service Code if the child resided in any type of specialized foster home placement receiving a negotiated specialized rate prior to the finalization of the adoption or if approval granted post finalization via the Post Adoption and Guardianship Services Review Committee. If approval is granted post finalization via the Post Adoption and Guardianship Services Review Committee, up to the equivalent DCFS standard rate may be granted. The amount of the subsidy must be manually entered by the Regional Post Adoption Unit. These cases will not receive automatic increases based on cost of living adjustments. Central Office will adjust the subsidies manually to reflect cost of living adjustments when appropriate. Cases receiving specialized rates are not eligible for increases based on age.

Type Service Code	0338	Adoption Subsidy – (No Increases Due to Age or Cost of Living)

Instructions: Use this Type Service Code for any adoption assistance case where the adoptive parent(s) have indicated that they do not want cost of living increases or adjustments based on the child's age. The Region must manually enter the rate.

Type Service Code	0350	Adoption Subsidy Under Age 19 In School

Instructions: Use this Type Service Code for any adoption assistance case where the child is age 18 and is still attending school, proof of which must be in the case file. The rate will mirror that prior to the child turning age 18 and must be entered manually. Payments may continue until the youth's 19th birthday or until their graduation from high school or equivalent; whichever comes first.

Documentation of School:

- Documentation must include verification of school attendance and estimated date of graduation.
- If the 18th birthday is during the summer, documentation must include previous school year attendance and a subsequent letter in the fall detailing the date of graduation.

Do not use the school codes if the youth has a ***documented disability*** (see below).

Type Service Code	0355	Adoption Subsidy Under Age 21 With a Disability

Instructions: Use this Type Service Code for any adoption assistance case where the child is between age 18 and 21 and has a disability, the onset of which preceded the finalization of the adoption and proof of which is in the case file. The rate will mirror that prior to the child turning age 18 and must be manually entered.

Documentation of Disability:

- Letter from Social Security Administration indicating the youth is eligible for SSI.
- Letter or report from a medical professional stating the mental or physical condition, the onset of which preceded the finalization of the adoption, and meets the definition of disability per the Americans with Disabilities Act of 1990.

b) Special Payments

The following payments may be made on behalf of children adopted with adoption assistance regardless of the date the adoption assistance agreement was submitted to the family.

The Department will not subsidize non-recurring adoption expenses for persons who adopt children who do not qualify for adoption assistance, or who qualify only for conditional adoption assistance. The total amount paid for non-recurring expenses of adoption, including legal fees, cannot exceed $1500.00.

Type Service Code	0302	Non-Recurring Expenses Related to the Finalization of the Adoption

Instructions: The Department will pay a maximum of $1500.00 per adopted child for nonrecurring adoption expenses that are directly related to the legal adoption of a child with special needs. Adoptive parents shall select the attorney of their choice. The only limitation is that the attorney must be licensed to practice law in Illinois.

Adoptive parents should be advised to call the DCFS Advocacy Office for Children and Families at (800) 232-3798 or check the DCFS website at www.state.il.us/dcfs to receive a current list of attorneys on the DCFS Adoption Attorney Panel. Under no circumstances should an employee of the Department or a private agency refer an adoptive parent to a specific attorney.

1) Payment Directly to Adoption Attorneys

DCFS will pay attorneys who are on the State Adoption Attorney Panel directly on behalf of adoptive families for necessary and reasonable legal fees and costs. The attorney shall submit to the Department an itemized invoice with a copy of the adoption petition, interim order and final judgment.

2) Reimbursement to Adoptive Families Who Use Attorneys Who Are Not On the Statewide Adoption Attorney Panel

When an adopting parent selects an attorney who is not on the Statewide Adoption Attorney Panel, DCFS will reimburse the adoptive parent for attorney fees and costs, up to the maximum of $1500.00 per adopted child.

For Cook County adoptions Adoptive parents may send requests for reimbursement to:

DCFS Post-Adoption and Guardianship Unit
1921 S. Indiana, 4th Floor
Chicago, IL 60616

For adoptions outside of Cook county, adoptive parents may send requests for reimbursement to their appropriate DCFS Regional Office for Downstate adoptions

Adoptive parents must include an itemized invoice from the attorney, proof of payment by the adoptive parent, and copies of the adoption petition, interim order and final judgment.

3) Payment for Adoptions Not Finalized or For Adoptions That Are Vacated

Payment may also be made for services rendered if the adoption is never finalized or is vacated ***THROUGH NO FAULT OF THE ATTORNEY***, when the attorney submits a statement itemizing expenses incurred up to the point the adoption is abandoned, provided an agreement for adoption assistance was previously established.

Attached to the itemized statement submitted must be a copy of the document filed with the court to vacate the adoption petition, interim order or final judgment identifying the facts regarding why the adoption was withdrawn or vacated. If withdrawing from the case prior to filing the petition or interim order, the attorney must attach to the itemized statement a detailed letter outlining the reasons the adoption was not finalized. Payment for all nonrecurring expenses, including legal fees cannot exceed $1500.00 per adopted child.

4) Payment for Standby Adoption

Legal fees for a standby adoption for which adoption assistance is provided may be paid in two (2) installments: 1) when the order of standby adoption is issued; and 2) following the finalization of the adoption.

For the first payment submit an itemized statement and attach a copy of the Interim Order for Standby Adoption. For the final payment submit an itemized statement and a copy of the final judgment.

Type Service Code 0303 Medical Services

Instructions: One time only or continuous payment may be made for any child receiving ongoing monthly payments who need medical services related to conditions which existed prior to the child's adoption which are not covered by the adopting family's medical insurance, by the Division of Specialized Care for Children or by the Department of Health and Family Services (DHFS). Eligibility for this assistance must be re-determined whenever the family or child's circumstances change but at least annually to determine whether the adoptive parent(s) remains legally and/or financially responsible for the child in order for payments to continue. See 359.90 for medical services and provider information for services covered by DHFS.

There are three different categories under which children adopted with adoption assistance may fall:

- Children adopted prior to June 17, 1980 are not eligible for Medicaid. The Department assumes responsibility for payment of medical services related to a medical condition that existed prior to the adoption when there is no family insurance or any other financial resource.

- Children adopted between June 17, 1980 and January 1, 1986 may or may not be covered by Medicaid. If the child is Medicaid eligible, the Department assumes responsibility for only those expenses related to the child's preexisting condition that is not DHFS covered services or are provided by a non-enrolled DHFS medical vendor.

  (If the child is not covered by Medicaid, the Department assumes responsibility for any medical service related to the child's preexisting condition that is not covered by the family's insurance or another financial resource.)

- All children adopted after January 1, 1986 are Medicaid eligible. The Department assumes payment responsibility only for those medical services related to any preexisting conditions that are not Medicaid covered or that are provided by a non-enrolled DHFS provider.

Type Service Code 0308 Physical, Emotional and Mental Health Needs Payable Following Finalization of an Adoption

Instructions: Payment may be approved for physical, emotional and mental health needs provided that the services are not covered by the family's insurance, DHFS, or any other financial resource, and that the services are related to the child's documented preexisting condition. Counseling and/or therapy are examples of such services. Payment cannot be made until the Department has been notified in writing that the services will begin and has approved the requested services and executed a contract (when applicable). Eligibility for continued services must be re-determined whenever the circumstances of the family or child change but at least annually.

Type Service Code 0310 Therapeutic Day Care

Instructions: Payment is available only for those children who have been determined to have a disability which requires special educational services through an Individualized Education Plan (IEP), an Individual Family Services Plan (IFSP), or a CFS 504 – Educational Special Needs Plan, and not fundable through another resource. Specific therapeutic interventions must be provided as an integral part of the day care programming. Payment cannot be made until the Department has been notified in writing that the services will begin and has approved the requested services, and a contract has been executed (when applicable).

5) Employment Related Day Care

Payment may be made for day care for children under the age of three years when the adoptive parent(s) is employed or in a training program which will lead to employment. Payment for day care services will end on the child's third birthday.

Type Service Codes:

0361--AA/SG Day care--Licensed Day Care Center
0362--AA/SG Day care--Licensed Exempt Center
0363--AA/SG Day care--Licensed Day Care Home
0364--AA/SG Day care--Licensed Exempt Home
0365--AA/SG Day care--Home Network
0366--AA/SG Day care--Non-Relative Childs Home
0367--AA/SG Day care--Relative Relatives Home
0368--AA/SG Day care--Relative Childs Home
0369--AA/SG Day care--Licensed Group Day Care Home

6) Respite Care

Payment for respite care not to exceed ten (10) days per fiscal year may be made for those children who met the medical eligibility guidelines used by DHFS for the Home and Community Based Services (HCBS) Waiver program for Children who are Medically Fragile/Technology Dependent.

c) Special Payments Applicable Only to Adoption Assistance Agreements Submitted to the Family Prior to November 28, 1995

Type Service Code		Document
0307	Special Service Fees Adoption Assistance	CFS 906-4

See Appendix A(I)(b) for maximum amounts that may be applied to one or a combination of the following services:

- Transportation related to medical or school needs;
- Diet related to medical needs; and/or

- Expenses related to special care based on the physical, mental and emotional problem/handicap of the child.

Special service fees may have been included in adoption assistance agreements submitted to the family **prior** to November 28, 1995. Adoption assistance agreements submitted to the family on or after November 28, 1995, **are not** eligible for other special service payments.

Continuation of all special service fee payments requires the recommendation of the adoption coordinator and the approval of the Regional Administrator. The expenses shall be documented in the case record and shall be reviewed at time of renewal.

Type Service Code (Other Special Service fees)		Document
0304	Adoption Subsidy-Health Insurance	CFS 932
0310	Adoption-Other Special Services Specialized Camp Fees; Tutoring; Respite Care	CFS 906

Time limited payments may have been negotiated **prior** to November 28, 1995, for services required as a result of the child's physical, mental or emotional condition or conditions that existed prior to the child's adoption and which are not covered by the adopting family's insurance, by DSCC, DHFS or by any other financial source. These payments may be continued only if the need for these services was specified in an adoption assistance agreement submitted to the family prior to November 28, 1995. Adoption assistance agreements submitted to the family on or after November 28, 1995, **are not** eligible for other special service payments.

Continuation of other special services requires the recommendation of the adoption coordinator and the approval of the Regional Administrator. The expenses shall be documented in the case record and shall be reviewed at time of renewal.

Note: See Section 359.70 for Instructions on Travel for Pre-placement Visits for Prospective Adoptive Parents for additional information.

d) Interim Payments for Dissolved Adoptions

Ongoing monthly subsidy payments may be authorized to an interim caregiver who is in the process of adopting the child(ren) in their care, due to the death of the prior adoptive parent. These payments may begin once the interim subsidy agreement is signed by all appropriate parties. Payment may be made to the interim caregiver retroactively back to the date the interim caregiver began caring for the child/ren after the death of the adoptive parent. These payments are to be discontinued upon the finalization of the new adoption, at which time the adoption subsidy agreement becomes effective. If at any point the interim caregiver is not proceeding with the adoption, the interim payments should be terminated.

Type Service Code	4999	Interim Payment Prior to signed interim agreement
Type Service Code	4901	Interim Payment Prospective Placement

Instructions: Use Type Service Code 4999 for payments to the interim caregiver for the period of time prior to the signing of the interim subsidy. Use Type service code 4901 for payments to the interim caregiver from the date the interim subsidy is signed to the date of the finalization of the new adoption. These codes are entered by The Central Office Client Payment Unit (CPU) upon receiving notification of the approved interim subsidy. The monthly rate is manually entered to equal the previous rate paid under the dissolved adoption agreement.

e) Non-ward Adoption Subsidy Payments

Adoption subsidy payment can be made by the Department for adopted children who were not former DCFS wards, if they meet one or more of the following criteria:

- The child was not under the placement and care of DCFS when the petition was filed, but does meet special needs criteria. This child is eligible for non-recurring expenses only.
- The child for whom DCFS does not have placement and care responsibility when the adoption petition was filed, but was eligible for AFDC (under the provision of Title IV-A of the Social Security Act as of July 16, 1996) at the time he/she was removed from the home, and in the month the adoption petition was initiated.
- The child is a non-ward, but is a child of a minor parent receiving Title IV-E foster care maintenance payments.
- The child was not under the placement and care of DCFS, but was SSI eligible at the time the adoption petition was filed.
- The child was previously adopted with Adoption Assistance and continues to be eligible in a new adoption.

Type Service Code 0302 Non-Recurring Costs

Instructions: Nonrecurring expenses are those considered to be one time only expenses incurred during and related to the adoption process. Eligible expenses include but are not limited to: reasonable and necessary adoption fees, court costs, attorney fees, guardian ad litem fees, travel expenses related to pre-placement visits, health and psychological examinations and any other costs associated with the adoption finalization of a child with special needs.

Type Service Code	0339	Equal to the foster care board rate (See Appendix A(I)(c)for amounts) on non-ward adoptions effective prior to July 1, 2006

Instructions: Use this Type Service Code for a non-ward adoption subsidy equivalent to the standard foster care rate, based on the age of the child for adoptions effective prior to July 1, 2006.

Type Service Code	0347	Equal to the foster care board rate on non-ward adoptions effective after June 30, 2006

Instructions: Use this type service code for a non-ward adoption subsidy equivalent to the standard Foster care rate, based on the age of the child. This type service code is to be used on Adoptions effective after June 30, 2006.

Type Service Code	0318	Equal to the foster care board rate on non-ward adoptions effective after September 30, 2008

Instructions: Use this type service code for a non-ward adoption subsidy equivalent to the standard Foster care rate, based on the age of the child. This type service code is to be used on Adoptions effective after September 30, 2008.

Type Service Code	0349	Non-ward Specialized Manually Entered

Instructions: Use this Type Service Code if the non-ward is approved to receive a negotiated, specialized subsidy rate which was part of the adoption agreement. The rate from the adoption agreement must be manually entered by the Post-Adoption Unit. These cases will not receive automatic increases based on cost of living adjustments. Central Office will adjust the subsidies manually to reflect cost of living adjustments when appropriate. Cases receiving specialized subsidy rates are not eligible for increases based solely on age.

Type Service Code	0351	Non-ward Adoption Subsidy Under Age 19 In School

Instructions: Use this Type Service Code for any non-ward adoption assistance case where the child is age 18 and is still attending school, proof of which must be in the case file. The rate will mirror that prior to the child turning age 18 and must be entered manually. Payments may continue until the youth's 19th birthday or until their graduation from high school or equivalent; whichever comes first.

Documentation of School:

- Documentation must include verification of school attendance and the estimated date of graduation.
- If the child's 18th birthday is during the summer, documentation must include previous school year attendance and a subsequent letter in the fall detailing the date of graduation.

Do not use this Type of Service if the youth has a disability.

Type Service Code	0352	Non-ward Adoption Subsidy With a Disability

Instructions: Use this Type Service Code for any non-ward adoption assistance case where the child is between age 18 and 21 and is disabled, proof of which is in the case file. The rate will mirror that prior to the child turning 18 and must be manually entered.

Documentation of Disability:

- Letter from Social Security Administration indicating the youth is eligible for SSI.
- Letter or report from a medical professional stating the mental or physical condition that meets the definition of disability per the Americans with Disabilities Act of 1990.

Section 359.44 Payments for Subsidized Guardianship

The Subsidized Guardianship Program is a child welfare demonstration project for which federal waivers have been received. It is available in all areas of the state with the exception of those areas that have been designated as cost neutrality areas in Rule 302.405(f). In those areas clients will be randomly assigned to a group that is eligible to participate in the demonstration project, or to a cost neutrality group subject to the regular services of the Department.

a) Subsidized Guardianship - Special Rates

Type Service Codes		Document
0150	Subsidized Guardian Subsidy-Intensive Rate	CFS 906
0186	Subsidized Guardian Subsidy-HMR Manually Calculated	CFS 906
0188	Subsidized Guardian Subsidy-Non-Related Manually Calculated	CFS 906
0189	Subsidized Guardian Subsidy-Special Rates	CFS 906

Instructions: Use Type Service Code 0189 if the child resided in any type of specialized foster home placement receiving a negotiated specialized rate prior to the transfer of guardianship or if approval granted post finalization via the Post Adoption and Guardianship Services Review Committee. If approval is granted post finalization via the Post Adoption and Guardianship Services Review Committee, up to the equivalent DCFS standard rate may be granted.

b) Subsidized Guardianship – Relative Home Subsidy (HMR)

Type Service Codes		Document
0193	Subsidized Guardian Subsidy - Relative Home – for cases where guardianship was granted prior to July 1, 2006	CFS 906
0373	Subsidized Guardian Subsidy – Relative Home – for cases where guardianship was granted after June 30, 2006	CFS 906
<u>0376</u>	<u>Subsidized Guardian Subsidy – Relative Home – for cases where guardianship was granted after September 30, 2008</u>	<u>CFS 906</u>

Instructions: Use these Type Service Codes if the child was receiving any type of relative home payments prior to the transfer of guardianship.

c) Subsidized Guardianship - Non-relative Home Subsidy

Type Service Codes		Document
0194	Subsidized Guardian Subsidy/Non-Relative Home – for cases where guardianship was granted prior to July 1, 2006	CFS 906

0374	Subsidized Guardian Subsidy/Non Relative Home – for cases where guardianship was granted after June 30, 2006	CFS 906
0377	Subsidized Guardian Subsidy/Non Relative Home – for cases where guardianship was granted after September 30, 2008	CFS 906

Instructions: Use these Type Service Codes if the child was receiving any type of regular foster care payments in the home of a foster parent who was not related to the child.

d) Subsidized Guardianship – Subsidy for youths 18 Years of age and Older

Type Service Codes		Document
0370	Subsidized Guardian Subsidy/Under Age 19 In School	CFS 906

Instructions: Use this Type Service Code for any subsidized guardianship case where the child is age 18 and is still attending school, proof of which must be in the case file. The rate will mirror that prior to the child turning age 18 and must be entered manually. Payments may continue until the youth's 19th birthday or until their graduation from high school or equivalent; whichever comes first.

Documentation of School:

- Documentation must include verification of school attendance and estimated date of graduation.

- If the 18th birthday is during the summer, documentation must include previous school year attendance and a subsequent letter in the fall detailing the date of graduation.

  Do not use the school codes if the youth has a disability (see below).

Type Service Code		Document
0375	Subsidized Guardian Subsidy/Under 21 With Disability	CFS 906

Instructions: Use this Type Service Code for any subsidized guardianship case where the child is between age 18 and 21 and has a disability, the onset of which preceded the transfer of guardianship, and proof of which is in the case file. The rate will mirror that prior to the child turning age 18 and must be manually entered.

Documentation of Disability:

- Letter from Social Security Administration indicating the youth is eligible for SSI.
- Letter or report from a medical professional stating the mental or physical condition whose onset preceded the transfer of the guardianship and meets the definition of disability per the Americans with Disabilities Act of 1990 (See AP #5for additional information).

e) Subsidized Guardian/Counseling

Type Service Code		Document
0430	Subsidized Guardian-Counseling	CFS 932

Instructions: When unusual or unexpected circumstances arise that may impair the guardian's ability to maintain the permanency goal, payment for counseling services may be authorized on a case-by-case basis.

f) Subsidized Guardian/Medical, Emotional and Mental Health

Type Service Code		Document
1130	Subsidized Guardian-Medical	CFS 932

Instructions: One-time only or continuous payment may be made for any child receiving subsidized guardianship who needs medical, emotional or mental health services related to conditions that existed prior to the transfer of guardianship which are not covered by the guardian's medical insurance, by the Division of Specialized Care for Children or by the Medicaid Program.

g) Subsidized Guardian/Therapeutic Day Care

Type Service Code		Document
0310	Therapeutic Day Care	CFS 932

Instructions: Payment is available only for those children who have been determined to have a disability which requires special educational services through an Individualized Education Plan (IEP), an Individual Family Services Plan (IFSP), or a **CFS 504, Educational Special Needs Plan**, and not fundable through another resource. Specific therapeutic interventions must be provided as an integral part of the day care programming. Payment cannot be made until the Department has been notified in writing that the services will begin and has approved the requested services, and a contract has been executed (when applicable).

h) Employment Related Day Care

Payment may be made for day care for children under the age of three years when the subsidized guardian(s) is employed or in a training program which will lead to employment. Payment for day care services will end on the child's third birthday.

Type Service Codes:

0361--AA/SG Day care--Licensed Day Care Center
0362--AA/SG Day care--Licensed Exempt Center
0363--AA/SG Day care--Licensed Day Care Home
0364--AA/SG Day care--Licensed Exempt Home
0365--AA/SG Day care--Home Network
0366--AA/SG Day care--Non-Relative Childs Home
0367--AA/SG Day care--Relative Relatives Home
0368--AA/SG Day care--Relative Childs Home
0369--AA/SG Day care--Licensed Group Day Care Home

i) Respite Care

Payment for respite care not to exceed ten (10) days per fiscal year for those children who met the medical eligibility guidelines used by DHFS for the Home and Community Based Services (HCBS) Waiver program for Children who are Medically Fragile/Technology Dependent.

j) Subsidized Guardian/Legal, Non-recurring Expenses

Type Service Code		Document
1930	Subsidized Guardian/Legal, Non-recurring Expenses	CFS 932

Instructions: Payments of one-time court costs and legal fees, if required, in connection with the establishment of guardianship, up to a maximum of $500.00. Prospective guardians shall select the attorney of their choice. The chosen attorney must be licensed to practice law in Illinois.

To receive a current list of attorneys on the DCFS Adoption Attorney Panel, prospective guardians should be advised to call the DCFS Office of Advocacy for Children and Families at (800) 232-3798 or to the current list from the DCFS website at www.state.il.us/dcfs. Under no circumstances should an employee of the Department or a private agency refer a prospective guardian to a specific attorney.

1) Direct Payment to Attorneys

DCFS will pay attorneys who are on the Statewide Adoption Attorney Panel directly on behalf of prospective guardians for necessary and reasonable legal fees and costs. The attorney shall submit to the Department an itemized invoice with a copy of the guardianship order and verification of subsidy review form.

2) Reimbursement to Families Who Use Attorneys Who Are Not On the Statewide Adoption Attorney Panel

When a prospective subsidized guardian selects an attorney who is not on the Statewide Adoption Attorney Panel, DCFS will reimburse the prospective subsidized guardian for attorney fees and costs, up to the maximum of $500.00 per child. Subsidized guardians who reside in Cook County may send requests for payment to:

DCFS Post-Adoption and Guardianship Unit
1921 S. Indiana, 4th Floor
Chicago, IL 60616

Subsidized guardians who reside Downstate may send requests for payment to their appropriate DCFS Regional Office.

Included must be an itemized invoice from the attorney, proof of payment by the guardian, and copies of the guardianship order and verification of subsidy review form.

3) Payment for subsidized guardianships not finalized or for subsidized guardianships that are vacated

Payment may also be made for services rendered if the subsidized guardianship is never finalized or is vacated ***THROUGH NO FAULT OF THE ATTORNEY,*** when the attorney submits a statement itemizing expenses incurred up to the point the subsidized guardianship is abandoned, provided an agreement for subsidized guardianship was previously established.

Attached to the itemized statement submitted must be a copy of the document filed with the court to vacate the subsidized guardianship petition, or final order identifying the facts regarding why the subsidized guardianship was withdrawn or vacated. If withdrawing from the case prior to filing the petition for subsidized guardianship, the attorney must attach to the itemized statement a detailed letter outlining the reasons the subsidized guardianship was not finalized. Payment for all nonrecurring expenses, including legal fees cannot exceed $500.00 per child.

4) Payment for Standby Guardianship Legal Fees

Legal fees for a standby guardian for which subsidized guardianship is provided may be paid in two (2) installments: 1) when the order of standby guardianship is issued; and 2) following the awarding of the guardianship.

For the first payment submit an itemized statement and attach a copy of the Order Appointing Standby Guardian of a Minor. For the final payment submit an itemized statement and a copy of the Order for Guardianship.

k) Interim Payments for Dissolved Subsidized Guardianships

Ongoing monthly subsidy payments may be authorized to an interim caregiver who is in the process of become the guardian of the child(ren) in their care, due to the death of the prior subsidized guardian. These payments may begin once the interim subsidy agreement is signed by all appropriate parties. Payments may be made to the interim caregiver retroactively back to the date the interim caregiver began caring for the child/ren after the death of the guardian. These payments are to be discontinued upon the finalization of the new guardianship, at which time the guardianship subsidy agreement becomes effective. If at any point the interim caregiver is not proceeding with the guardianship, the interim payments should be terminated.

Type Service Code	4999	Interim Payment Prior to signed interim agreement
Type Service Code	4901	Interim Payment Prospective Placement

Instructions: Use type service code 4999 for payments to the interim caregiver for the period of time prior to the signing of the interim agreement. Use Type Service Code 4901 for payment from the date the approved interim subsidy is signed up to the date of the finalization of the new guardianship. These codes are entered by The Central Office Client Payment Unit (CPU) upon receiving notification of the approved interim subsidy. The monthly rate is manually entered to equal the previous rate paid under the dissolved guardianship agreement.

Section 359.45 Payments for Foster Care Support Services

The following services/programs are included in this section:

- Foster Parent Training and Recruitment;
- Permanency Planning Contracts;
- Agency Adoption Contracts;
- Foster Parent Support Program;
- Crisis Support Services for DCFS Supervised Foster Parents; and
- Respite Care for Foster Parents.

a) Foster Parent Training and Recruitment

1) Foster Parent Training and Recruitment Contracts

Type Service Code		Document
0112	Foster Parent Training and Recruitment	CFS 1042

Instructions: Contracts for training and/or recruitment of foster parents may be negotiated with an individual or agency demonstrating expertise in the field. Approval of the Regional Administrator or designee is needed for the payment document. Rates are negotiated by contract or agreement.

2) Direct Payment and Reimbursement for Foster Parent Training and Recruitment

Type Service Code		Document
0116	Training Reimbursement for Foster Parents	CFS 932
0130	Direct Payment of Foster Parent Training Expenses	CFS 1042

Instructions: The cost of registration fees, in-service training sessions and related travel costs, including babysitting for the children of individual DCFS foster parents or relative caretakers, may be reimbursed by voucher to the foster parents or relative caretakers if adequate documentation (receipts showing proof of expenditure by foster parents) is attached to the voucher. Use Type Service Code 0116 when reimbursing foster parents or relative caretakers. Payment for the above expenses may also be made directly to the provider using Type Service Code 0130. Actual expenses are negotiated. Approval of Regional Administrator or designee needed for payment document.

b) Permanency Planning Contracts

Type Service Code		Document
0405	Permanency Planning Contracts	CFS 1042

Instructions: Contracts may only be entered into for children in substitute care. The program plan details the minimal contractual requirements; additional stipulations may be negotiated. The payment provision in the program plan is the maximum cost standard; lower rates may be negotiated. Regional Administrator or designee approval needed for payment document.

c) Agency Adoption Contracts

1) Agency Adoption Contracts - Standardized Program Plan

Type Service Code		Document
0305	Adoption Contracts/ Standard Program	CFS 1042

Instructions: Contracts may only be entered into with licensed child welfare agencies. The standardized program plan and payment provisions must be attached to the contract. The program plan details the minimal contractual requirements; additional stipulations may be negotiated. The payment provision in the program plan is a maximum cost standard; lower rates may be negotiated. The approval of the Regional Adoption Coordinator is required for the payment document.

2) Agency Adoption Contracts - Non-Standardized Program Plans

Type Service Code		Document
0306	Adoption Contracts/ Non-Standard Program	CFS 1042

Instructions: Contracts may only be entered into with licensed child welfare agencies. The program plan and payment provisions must be attached to the contract. Contracts should not be entered into for pre-adoptive counseling. Pre-adoptive counseling contracts are payable from the counseling line. The program plan details the minimal contractual requirements; additional stipulations may be negotiated. The payment provision in the program plan is a maximum cost standard; lower rates may be negotiated. Approval of the Regional Adoption Coordinator is required for payment.

d) Foster Parent Support Program

Type Service Code		Document
0111	Foster Parent Support Specialists	CFS 1042

Instructions: Payments may be made to Foster Parent Support Specialists who provide supportive and instruction services to licensed foster parents within the specific geographical area. Hourly rates may be negotiated between the Regional Contract Administrator and the Foster Parent Support Specialist.

e) Crisis Support Services for DCFS Supervised Foster Parents

Type Service Code		Document
0131	Crisis Support Services	CFS 932
	Reimbursement to Foster Parents or Relative caretaker	CFS 1042
	Direct Payment of Provider	

Instructions: Counseling, consultation, and other similar supportive services may be provided on behalf of DCFS supervised foster parents and approved relative home caretakers to avoid placement disruption in times of crisis related to the behavior of the ward or to the ward's biological family. Up to five hours of consultation per incident may be provided to the foster family in times of crisis caused by problems within the foster family itself. Expenses will be paid as negotiated. Payment may be made directly to the provider or as reimbursement to the foster parents or relative caretaker with prior approval. Approval of the Family Development Coordinator is required.

f) Respite Care for Foster Parents

Type Service Code		Document
0132	Respite Family Habilitation Services	CFS 932
	Reimbursement to Foster Parents or Relative Caretaker	CFS 1042
	Direct Payment of Provider	
0133	Respite Family Habilitation Services	CFS 932
	Child Care Services,	CFS 1042
	Reimbursement to Foster Parents or Relative caretaker	
	Direct Payment of Provider	

Instructions: Respite care may be provided to licensed DCFS foster parents in times of crisis to prevent placement disruption. Examples of respite care include but are not limited to, around the clock family habilitation services or childcare services in a licensed foster family home. These services may be paid through Type Service Codes 0132 or 0133.

Respite care placement are subject to approval and must be cleared by the Placement Clearance Desk as described in **Procedures 301, Placement and Visitation Services, Appendix E, Placement Clearance Process**.

When temporary short-term placement of the child is required, intermittent foster care up to a maximum of five days may be used. Use Type Service Code 0117 or 0120 depending on the type of foster care. For further instructions see the procedures for the particular type of foster family care [pages P359.40 – P359.45 (1) through (15)] for which intermittent care is being used. Expenses will be paid as negotiated. Payment may be made directly to the provider or as reimbursement to the foster parents or relative caretaker with prior approval. Approval of the Family Development Coordinator is needed.

FAMILY PRESERVATION AND AUXILIARY SERVICES

Section 359.50 Payments for After Care Services

a) Foster Care/Relative Home Care

Type Service Code		Document
0108	Foster Care After Care	CFS 1042

Instructions: Licensed child welfare agencies under DCFS contract may receive payment for the continuation of social services to a child and his or her family when placed from Department or private agency foster care for after care. Rate negotiated by contract. Effective July 1, 2006, this Type Service Code is no longer being used.

b) Institution and Group Home

Type Service Code		Document
0205	Institution/Group Home After Care	CFS 1042

Instructions: Payment may be made to a licensed child welfare agency for the continuation of social services to a child and his or her family when the child is placed from a child care institution or group home for after care.

Section 359.51 Payments for Family Habilitation Services

a) Family Habilitation and Individual Emergency Caretaker Services

Type Service Code		Document
0502	Family Habilitation Worker - Service and Expenses	CFS 1042
0503	Medical Examinations	CFS 932 or CFS 1042
1407	Child Travel for Parental Visitation – (effective 11/1/07)	CFS 932 or CFS 1042
1414	Parent Travel for Parental Visitation – (effective 11/1/07)	CFS 932 or CFS 1042

Instructions: Payment will not be made for supplies, meals, or activities outside the realm of the contract. Payment may be made at the negotiated hourly rate for the actual hours on assignment. Family Habilitation Workers shall not be assigned responsibilities that cause them to work more than 40 hours per week unless special contract approval has been received from the Director. When the Family Habilitation Worker is attending staff development sessions or case-related supervisory conferences, payment is made at the negotiated hourly rate for travel time and the time in attendance. A client I.D. must be assigned to all payments except medical examinations, training and travel to and from training. For these three types of expense, the I.D. will be 999999 followed by the region number, e.g. 1A.

The approval of the Regional Administrator is needed for the contract if a standardized program plan has been approved; the approval of the Director is needed for non-standardized program plans.

Family Habilitation Workers who work by the hour will be paid at the hourly rate negotiated by the Regional Administrator, as permitted in the approved DCFS individual wage scale. The rate will not be lower than the minimum wage.

Payment of Transportation

Reimbursement for the cost of travel shall be in accordance with the Department of Central Management Services (DCMS) travel rates and DCFS travel regulations. Reimbursement for travel time and travel costs shall be part of the contract. When Family Habilitation Workers are used for parental visitation transportation, Type Service Code 1407 shall be used for reimbursement of expenses for transporting the child and type service 1414 should be used for expenses related to transporting the parent. Reimbursement will be made for reasonable amounts spent for bus fare, or taxi fare where no bus transportation is available. Family Habilitation Workers using their own cars for transportation shall have a driver's license and proof of public liability coverage and property damage in their insurance policies. Proof shall be available in the Regional contract file. Recommended coverage is $100,000 each person, $300,000 each accident, and $25,000 for property damage or the minimum as required by law.

Payment for Medical Examination

Family Habilitation Workers may be reimbursed for the required physical examinations, tuberculin skin test, and, if indicated, chest x-ray and other laboratory tests prescribed by the physician and/or Department. Family Habilitation Workers are to be encouraged to use the benefits of private health coverage if the Family Habilitation Worker is covered by an existing insurance policy. See Appendix A (II) (c) for amounts allowed per examination. Bills over the allowable rate must have prior approval in writing from the Regional Administrator or designee and such prior approval shall be kept on file at the regional office. If the Family Habilitation Worker is to be reimbursed for the physical, such expenses are to be included in the reimbursable expense maximum of the contract.

b) Agency Family Habilitation Services

Type Service Code		Document
0507	Agency Family Habilitation Services	CFS 1042

Instructions: Payment may be made for Family Habilitation services to promote permanency by maintaining, strengthening and safeguarding the functioning of families to prevent substitute care placements, promote family reunification, stabilize foster care placements and facilitate youth development. This program will be distinct and separate

from any other homemaker services provided to other state agencies. It was developed to define the higher level of services.

c) Family Habilitation Training

Type Service Code		Document
0505	Family Habilitation Training	CFS 1042

Instructions: Payment may be made at negotiated hourly rates for actual hours of work, or at reasonable prices per deliverable. A program plan shall detail the services to be provided, the target group receiving the services, the means to evaluate the success of the training, and the method of payment. The payment provisions shall detail hours of work and/or deliverables to be received. A budget outlining costs for services and expenses is required. Reasonable expenses directly related to the services may be compensated. Reimbursement for costs of travel shall be in accordance with the DCMS and DCFS travel regulations. Approval of the Regional Administrator or designee is required for payment document.

Section 359.52 Payments for Counseling and Psychological Assessments

a) Counseling/Advocacy Services

1) Individual Counseling Services

Type Service Code		Document
0402	Individual Counseling - Service and Expenses	CFS 1042

Instructions: Counseling purchased from an individual.

2) Agency Counseling Service

Type Service Code		Document
0401	Agency Counseling	CFS 1042

Instructions: Counseling services purchased from an agency.

3) Individual Advocacy Services

Type Service Code		Document
0404	Individual Advocacy- Service and Expenses	CFS 1042
0406	Advocate Medical Exam	CFS 1042

Instructions: Same as above, Procedures 359.51 (c) for Family Habilitation/Emergency Caretaker contracts. Reimbursements for travel time and travel costs shall be part of the contract and shall be made in accordance with DCMS and DCFS Travel regulations. Regional Administrator or designee approval for contract, if utilizing standard rate and program plan; Director for others; Supervisor

Team/Leader for payment documents. Rates are same as above for Family Habilitation /emergency caretaker services.

4) Agency Advocacy Services

Type Service	Code		Document
0403		Agency Advocacy	CFS 1042

Instructions: Advocacy services purchased from an agency.

b) Family Psychiatric Evaluation

Type Service	Code		Document
1001		Psychiatric Evaluation and Consultation	CFS 1042

Instructions: Family psychiatric evaluations are available when a diagnostic evaluation is necessary to assist in developing a plan for the child's family. For assistance in locating potential providers through DHFS, contact the DCFS Regional Medical Liaison. The Regional Administrator or designee signature is needed for payment documents. Payment is made at the DHFS rate.

c) Family Psychological Evaluation

Type Service	Code		Document
0441		Psychological Evaluations - Ages 0-5	CFS 417 & CFS 1042
0442		Psychological Evaluations - Ages 6-Adult	CFS 417 & CFS 1042
0445		Home Based Assessments	CFS 417 & CFS 1042
0446		Other Psychological Evaluation Costs	CFS 417 & CFS 1042
0447		Bonding Assessments	CFS 417 & CFS 1042
0448		Allowance for Court Testimony	CFS 417 & CFS 1042
0450		Brief Dementia Screening	CFS 417 & CFS 1042
0451		Focused Neuropsychological Evaluation	CFS 417 & CFS 1042
0452		Comprehensive Neuropsychological Evaluation	CFS 417 & CFS 1042
0453		Parenting Capacity Assessment Fee	CFS 417 & CFS 1042

Instructions: Psychological evaluations can be performed by Illinois licensed psychologists approved by DCFS for the purpose of case planning. If the person to be evaluated resides outside of Illinois, proof of licensure of the evaluating psychologist from the other state is required in addition to DCFS credentials. Credentialing applications are available from the DCFS Division of Clinical Services.

Evaluations must include all applicable and appropriate testing, test scoring, diagnosis and report writing. To initiate payment for services, the examining psychologist shall prepare and submit a **CFS 1042, Billing Summary**. A separate **CFS 1042** is not needed for each type service code. Line 6 should be left blank and the Type Service Code must be included in Box 18. A copy of the **CFS 417, Referral Form for Psychological Evaluation**, must also be completed and pages one and six submitted with the billing for payment with the necessary authorization signatures. See Appendix A (II) (e) for amounts.

d) Family Planning Services

Type Service Code		Document
1117	Family Planning Services	CFS 932 or CFS 1042

Instructions: Payment may be made for prescription and physician family planning items/procedures when clients receiving DCFS services are unable to assume the medical costs and such services are not otherwise available in the community. Approval of the Regional Administrator or designee is required for payment documents. DPA rate is used.

Section 359.53 Payments for Camping for Children – Non-Wards

(For camping for wards, please see Section 359.7)

a) Camp Fees

Type Service Code		Document
1506	Camp Fees – Non-Wards (See Appendix A(II)(d) for amounts)	CFS 932 or CFS 1042
1510	Supervised Overnight Camping – Non-Wards	CFS 932 or CFS 1042

Instructions: Payment may be authorized for children receiving social services in their own homes when such is seen as essential for the child's social development and is identified in **CFS 497, Service Plan**. Camp also includes day camp. Regional Administrator approval is required prior to issuance of payment.

b) Camp Clothing

Type Service Code		Document
1204	Camp Clothing for Non-Wards/Required (See Appendix A(II)(d) for amounts)	CFS 932 or CFS 1042

Instructions: The need for clothing must be documented by written recommendation from the camp. Purchase Authorizations must be accompanied by camp's list of required items. Only items required by the camp can be purchased.

c) Camp Supplies

Type Service Code		Document
1508	Camp Supplies/Non-Wards (See Appendix A(II)(d) for amounts)	CFS 932 or CFS 1042

Instructions: To purchase camp supplies for activities which are not included in the camp fee.

d) Camp Transportation

Type Service Code		Document
1405	Camp Transportation for Non-Wards (See Appendix A(II)(d) for amounts)	CFS 932 or CFS 1042

Instructions: Payment is to be made to the provider of services only. **Parent is not to pay for service and expect reimbursement**. Transportation expenditure is allowable only for transportation to and from camp.

Section 359.54 Payments for Day Care Services

The following section describes the various types of day care and day care related services purchased by the Department. **Certain factors such as eligibility, age level, approval level, preconditions, and payment documents are generally the same for the various types of day care services described in this section. Exceptions to these are noted in the Instructions for the particular type of day care payment category.**

Procedures 302.330, Day Care Services, describes the types of day care services the Department will provide. In 1997, responsibility for non-DCFS employment related and training related day care was transferred to the Department of Health and Family Services (DHFS). Procedures 302.330 also describe how referrals are to be made to DHFS. DCFS has maintained the responsibility for Employment related day care for foster parents, parenting teen wards that are attending school and/or working (up to age 21); and Protective/Family Maintenance daycare for unemployed disabled foster parents, open intact families engaged in services and Family Reunification (for a period of 6 months from the date that the child returns home to their parent). All requests for day care outside of Cook County are referred to the Regional day care staff. The Regional Office is responsible for

approving and processing requests and payments for day care services. No payments will be made prior to the approval of the day care staff. In Cook County, day care may be requested and paid through the Cook County Office of Child Development.

Age level: Day Care is generally provided for children through age 12 or for children in foster care up to age 21who are seriously handicapped or developmentally disabled.

Preconditions: In order to receive payment for day care services a child care facility (center, group home, or program) must be licensed or license-exempt. The Department will not pay a facility/program for day care which is required to be licensed, but is not licensed and has not obtained written approval from DCFS Day Care Licensing to operate as a Facility or Program Exempt from Licensure. (Refer to Rules and Procedures 377, Facilities and Programs Exempt from Licensure).

Payment Documents:

The payment documents for day care services, unless otherwise noted in the Instructions are the **Child Care Monthly Enrollment Form**, which is generated by the AS400 Child Care System. The payment documents for Site Administered providers are the **CFS 420-21a & b**, including locally computerized versions of these forms.

Reimbursable Attendance Days

A day care provider will be reimbursed for eligible days if attended days for a child/children being funded by the Department in a licensed day care center are at least 80% of the eligible enrollment days for the month. If the percentage falls below 80%, the day care provider will receive reimbursement for actual attended days. The day care provider should not bill a DCFS client for the balance of the days for the month that the child did not attend the center (See Appendix D for attendance exemptions.) The attendance percentage may be calculated by combining all regionally administered children or all site administered children (City of Chicago CYS contract only) regardless of funding appropriations.

Authorized Rates: See Appendix A, section (V), for rates based on geographic location and type of day care provider.

a) Protective/Family Maintenance Day Care

Type Service Codes

0606	Protective/Family Maintenance Day Care Center
0607	Protective/Family Maintenance Day Care Home/Licensed
0608	Protective/Family Maintenance Day Care Home/License-Exempt
0609	Protective Day Care Babysitter
0610	Protective Day Care Relative
0617	Protective Day Care Family Home Network

0632 Protective Day Care Relative/Child's Home
0633 Protective Day Care License-Exempt Center
0634 Protective Day Care Licensed Group Family Home

Instructions: Payment can be made by DCFS for day care for children living in their own homes by DCFS when the service is identified on the **CFS 497 forms** (Service Plan) as necessary to protect the children or to maintain an intact family or for reunification (6 months). Day care may also be provided for non-DCFS families at risk of becoming involved with DCFS (special need cases) where day care is not employment related but is needed due to severe parent disability, hospitalization or a child's severe disability.

b) Therapeutic Day Care

Type Service Code
0615 Therapeutic Day Care

Instructions: Therapeutic day care is available only for children who are determined to have a disability that requires special educational services through an Individualized Education Plan (IEP) or an Individual Family Service Plan (IFSP) and is not fundable through another source. Specific therapeutic interventions must be provided as an integral part of the day care programming. Payment for therapeutic day care shall not be made until the Department has been notified in writing that such services will begin, has approved the requested services, and a contract has been executed (when applicable).

A contract is required for providers receiving $10,000 or more per eligible child during a fiscal year. Contracts must be approved by the Director. The Regional Administrator or designee approves the payment documents. **Authorized Rates** are **negotiated by contract**.

Preconditions are **CFS 968-18, CFS 1410** (child or family case); and **CFS 2000.**

The **payment document** is the **CFS 1042**.

c) Healthy Moms/Healthy Kids (HMHK) (formerly Day Care Infant Mortality)

Type Service Codes
0619 Day Care Service (for high risk infants)
0620 Training and Development
0677 HMHK/Licensed Day Care Center
0678 HMHK/License-Exempt Center
0679 HMHK/Licensed Group Day Care Home
0680 HMHK/Licensed Day Care Home
0681 HMHK/License-Exempt Home
0682 HMHK/Non-Relative/Child's Home
0683 HMHK/Relative/Relative's Home

0684 HMHK/Relative/Child's Home
0685 HMHK/Day Care Family Home Network

Instructions: Payment can be made for day care service provided for high risk or at-risk infants between the ages of 0 to 12 months and their preschool siblings unless an exception is approved by the Director of DCFS. No payments will be made prior to approval of the day care staff.

Requests for payment of higher than standard rates are negotiated as well as payment for necessary training, insurance and child care equipment. A contract would be required.

Preconditions are **CFS 968-18, CFS 2000, and Regional Day Care Form**.

Payment documents are **CFS 420-21a and b**; or the **CFS Child Care Monthly Enrollment Form**, which is generated by the Child Care System. **Authorized Rates** are negotiated by contract.

d) Foster Care Day Care

Type Service Codes
0663 Licensed Day Care Center/Foster Care Day Care
0644 License-Exempt Center/Foster Care Day Care
0655 Licensed Day Care Home/Foster Care Day Care
0666 License-Exempt Day Care Home/Foster Care Day Care
0667 Babysitter/Foster Care Day Care
0668 Relative's Home/Foster Care Day Care
0669 Licensed Group Day Care Home/Foster Care Day Care
0670 Day Care Agency/Foster Care Day Care
0671 Relative/Child's Home/Foster Care Day Care
0688 Family Home Network/Foster Care Day Care

Instructions: Payment for day care may be made for Department wards in Department or private agency foster care, if they require day care services due to employment or training leading to employment of the foster parent(s) or for other documented and necessary reasons (see Appendix A(V) for amounts). A more complete description of this day care program is contained in Appendix E, Employment Related Day Care for Foster Parents.

A rate add-on of $5.00 applies to Type Service Code 0688 for Site Administered or Regionally Administered day care.

The Regional Administrator or Cook County designee approves the payment documents.

Preconditions to payment are **CFS 1410** (child or family case), **CFS 2002, CFS 2003 and CFS 968-18.**

e) Day Care Center Registration Fee

Type Service Code
0689 Day Care Registration Fee

Instructions: The Department will pay up to $50.00 per child per school calendar year for Registration/Admission to a day care center, if required.

f) Day Care Transportation

Type Service Code		Document
1403	Day Care Transportation	CFS 1042

Instructions: Transportation to a licensed day care center or licensed day care home provider may be provided for children receiving Protective/Family Maintenance Day Care or Foster Care Day Care. No payment will be made prior to the approval of the day care staff.

Transportation will be provided for children through age 12 or children in foster care up to age 21 who are seriously handicapped or developmentally disabled.

If the day care provider provides transportation, the rate approved for day care includes the transportation cost. No additional payment beyond the maximum rate may be approved for transportation provided by the day care program or a related party. If transportation services are approved and may not be provided by the day care provider, it may be purchased from an unrelated source, such as a bus company or a transportation company. If the total expenditures with any one provider are expected to equal or exceed $ 10,000 during the fiscal year, a contract between the Department and the provider must be on file with the Illinois Comptroller.

Preconditions for payment are **CFS 1410** (child or family case), **Regional Day Care Request Form, and CFS 968-45**.

g) Drug Treatment/Project SAFE Day Care

Type Service Codes
0639 Drug Treatment/Project SAFE Day Care
0640 Drug Treatment Project SAFE/Day Care Expenses

Instructions: Payment may be made for day care services for children whose mothers are participating in Project SAFE programs or other Department sanctioned drug treatment programs, which are intensive outpatient alcohol/substance abuse treatment programs, and who are receiving other services from the Department. No payment will be made prior to the approval of the day care staff/Office of Child Development.

The approval for payment documents is at the Regional Administrator or designee level.

Preconditions to payment are **CFS 1410** (child or family) case, **CFS 968-18** (contracts if over blanket), **CFS 2000 or Regional Day Care Request Form**.

Payment documents are the **CFS Monthly Enrollment Form** and **Day Care Billing Form**, which are generated by the Child Care System.

h) Drug-free Families with a Future

Type Service Code	
0637	Drug-Free Families With A Future

Instructions: Day care service provided for infants who are high risk, due to substance abuse, and are between the ages of 0 to 12 months and their preschool-aged siblings. The Regional Administrator or Cook County designee approves the payment documents.

Preconditions to payment are **CFS 2000 or Regional Day Care Form** (contracts if over blanket).

i) Day Care Pre-Admission Physical Exam

Type Service Code		Document
1107	Physician Services	CFS 1042

Instructions: The Department will pay for the pre-admission physical examination for children for whom the Department is providing services when payment is not made through Medicaid. The Field Services Administrator approves the payment document, not the day care staff.

Payment will be made for children through age 12 or up to age 21 for children who are seriously handicapped or developmentally disabled.

Preconditions for payment are a **CFS 932**; and **CFS 1410** (child or family case).

Authorized Rates are in accordance with DPA rates, whenever possible.

j) Site Administered Day Care Agency – City of Chicago CYS Contract Only

Type Service Code		Document
0616	Site Administered Day Care Agency	CFS 1042

Section 359.55 Payments for Home Studies

a) Court Ordered Marriage Dissolution Home Studies

Type Service Code		Document
1690	Court Ordered Marriage Dissolution Home Studies	CFS 1042

Instructions: Unless a contract with the provider already exists in the line item out of which services will be paid, services may be paid from blanket obligations without a contract up to $9,999.99 per provider. If a contract already exists in the line item out of which services will be paid or if expenditures will be $10,000 or greater, a contract is required.

For all services the Client Service Plan (CFS 497) shall be used. When no contract is required the provider shall be given a copy of the Standard Program Plan and shall furnish a letter before the Department initiates any payments, which states that the provider understands the terms of the program plan and will follow them.

Home studies, reports and recommendations shall be prepared as specified in the Standard Program Plan. The worker shall initiate procedures to bill the responsible parties (parents) for the service. An open case is not required for families to be eligible for this service.

See Appendix A(II)(f) for amounts the Department will pay for court testimony. When two agencies or individuals share the responsibility for the home study due to differing geographic locations, see Appendix A(II)(f) for amounts the Department will pay per study.

b) Interstate Compact Home Studies

Type Service Code		Document
1691	Interstate Compact Home Studies	CFS 1042

Instructions: Home studies, reports and recommendations shall be prepared in accordance with the Standard Program Plan. An open case is not required of families to be eligible for this service. See Appendix A(II)(f) for amounts the Department will pay per study.

c) Court Ordered Adoption Home Studies

Type Service Code		Document
1692	Adoption Home Studies	CFS 1042

Instructions: Home studies, reports and recommendations shall be prepared as specified in the Standard Program Plan. The worker shall initiate procedures to bill the responsible parties (adoptive parents) for the service. An open case is not required for families to be eligible for this service. See Appendix A(II)(f) for amounts the Department will pay per study.

d) Court Ordered Supervised Visitation

Type Service Code		Document
1693	Court Ordered Supervised Visitation	CFS 1042

Instructions: Payments can be made for reports in accordance with the terms of the court order for children age 0 through 17 and their families or guardians. The worker shall initiate procedures to bill the responsible parties (parents) for the service. An open case is not required for families to be eligible for this service. See Appendix A (II) (f) for amounts the Department will pay per visitation.

Section 359.56 Payments for Family First Services

Intensive Family First services are directed to three target populations in accordance with the Family Preservation Act (effective January 1, 1988). The target populations are: families, one or more of whose children are the subject of an indicated report of abuse or neglect (receiving placement prevention services); families who have one or more children in foster care placement and for whom reunification is the goal (receiving family reunification services); and families who have adopted children whose adoption is in danger of dissolution (receiving adoption preservation services, sometimes called intensive post-adoption services).

a) Family Preservation Placement Prevention/Reunification Service Types

1) Grant Payment

Type Service Code		Document
3001	Family Preservation Services (FPS) Grant Payment	CFS 1042-F
3011	Family Reunification Services (FRS) Grant Payment	CFS 1042-F

Instructions: Payment can be made to cover providers' fixed expenses in the form of an advance grant paid quarterly or monthly based on program capacity by the Contracts Unit.

2) Family Preservation Professional Services

Type Service Code		Document
3002	FPS Counseling/Casework/ Collateral/Reports	CFS 1042-F
3012	FRS Counseling/Casework/ Collateral/Reports	CFS 1042-F

Instructions: Counseling, casework, collateral and court appearance services delivered by professional staff are billable under this service type, as are professionally prepared reports. See Appendix A for amounts.

3) Day Care Services

Type Service Code		Document
3003	FPS Day Care Services	CFS 1042-F
3013	FRS Day Care Services	CFS 1042-F

Instructions: Family Preservation Day Care services are reimbursed under this service type.

The lowest of the following rates is authorized: the rate paid to the subcontractor (if any); the maximum rate per Department Procedures Appendix A(V), or the charge of the day care center or home to the general public.

4) Homemaker Services

Type Service Code		Document
3004	FPS Homemaker Services	CFS 1042-F
3014	FRS Homemaker Services	CFS 1042-F

Instructions: Two types of services are authorized in this section: homemaker services performed by a caseworker and homemaker services performed by a paraprofessional.

Negotiated caseworker rates higher than the standard rate for homemaker services found in Appendix A (II)(g) must be discussed with the Office of Contract Administration before negotiation.

5) Emergency Cash Assistance

Type Service Code		Document
3005	FPS Cash Assistance	CFS 1042-F
3015	FRS Cash Assistance	CFS 1042-F

Instructions: Depending on need, an authorized DCFS supervisor may approve a total of $800 in cash assistance during a 12-month period to a family that is certified as a member of the Norman class. These funds may be provided in addition to Illinois Department of Human Services funds, other Department cash funds or funds provided by local community resources. The total amount of the cash assistance approved for the family may be disbursed to the family in a single payment or multiple payments over a 12-month period.

When a family's need exceeds $800, a DCFS Norman Liaison may approve cash assistance requests up to $1,600. A DCFS Regional Norman Liaison may approve requests up to $2,000. The Norman Program Coordinator or designee may approve requests up to $2,400. The Deputy Director of Service Intervention or designee must approve any request over $2,400. Actual, receipted expenses within the purposes outlined above will be reimbursed.

For service type code 3015, the purpose of emergency case assistance is to remove fiscal barriers to the reunification of a family. The same restrictions on usage apply to both service type codes 3005 and 3015.

6) Contractual Services

Type Service Code		Document
3006	FPS Contractual	CFS 1042-F
3016	FRS Contractual	CFS 1042-F

Instructions: This service type has two uses: as a "pass through" of service expenses subcontracted by the provider for client services only and as the service type under which Central Office pays trainers, evaluators and consultants. Providers are not to use this service type to bill non-client services. (Example: A service provider contracts with a consultant in order to strengthen service provision to clients. This is not billable, as such services are administrative support and included in the agency's grant or program rate. However, a provider may refer a particular family for a substance abuse evaluation. In this case the client is the direct recipient of services and the reasonable cost is billable.)

Rates should be reasonable and necessary for services. (In no case shall the Department reimburse a contractual service rate above the level paid by the general public for such services.)

7) Reimbursement of Training Expenses

Type Service Code		Document
3007	FPS Reimbursement Training Expenses	CFS 1042-F
3017	FRS Reimbursement Training Expenses	CFS 1042-F

Instructions: When the Department requires or requests in writing that the provider and staff attend a training session outside of the service area covered by the contractor, the Department will reimburse training expenses as set forth in “A Travel Guide For State of Illinois Employees” issued by CMS. Training expenses include mileage payments or required public transportation, lodging and meal or per diem expenses. Staff time is not billable under this service type. (For direct service staff time, service type codes 3002 and 3004 are used.)

8) Parenting Training

Type Service Code		Document
3008	FPS Parent Training	CFS 1042-F
3018	FRS Parent Training	CFS 1042-F

Instructions: Parenting training offered as a course to the family is reimbursable. Authorized rates are those prevailing in the Region in the parenting training services paid from other funds (typically the counseling appropriation). Payment rate for this service should be consistent with services paid from other funds regardless of the appropriation used to make the payment.

9) Operational Expenses

Type Service Code	
3009	FPS Operational Costs
3019	FRS Operational Costs

Instructions: This service type is used for personnel and fringe benefit blankets and other types of operational expenses. Its use is confined to Regional and Central Business Offices.

b) Adoption Preservation

1) Adoption Preservation Grant

Type Service Code		Document
3021	Adoption Preservation Services (AP) Grant Payment	CFS 1042-F

Instructions: Currently, a 100% grant is authorized for pilot Adoption Preservation services, which will be available not only to Department clients but to members of the general public. Rates are as authorized in award letters issued by the Department.

Special Note: This service type may also be used to issue advance payments for emergency cash assistance to providers under contract.

2) Purchased Services

Type Service Code		Document
3022	A P S Purchased Services	CFS 1042-F

Instructions: Under some circumstances purchased (rather than grant) services will be authorized.

3) Emergency Cash Assistance - Adoption Preservation

Type Service Code		Document
3025	A P S Cash Assistance	CFS 1042-F

Instructions: See service type 3005, FPS Cash Assistance. If non-grant cash assistance is contracted, payments shall be made from this service type.

4) Contractual Services

Type Service Code		Document
3026	A P S Contractual	CFS 1042-F

Instructions: See Service Type Code 3006.

5) Operational Expenses

Type Service Code	
3029	A P S Operational Costs (This service type is reserved for Business Office use)

c) Foster Care Service Type Associated with Family Reunification

Family Reunification Special Service Fees

Type Service Code		Document
0157	FRS Special Service Fee (No new requests granted after December 1, 2004)	CFS 906-4

Instructions: Special Service Fees are available based upon special needs including extraordinary transportation, ongoing unique costs, etc.

See Appendix A(I)(b) Special Service Fee chart for amounts, per month, per child to be approved by the Field Office Supervisor. The total service fee paid for children in placement in a particular foster home from a specific biological family shall not exceed per month the amount in Appendix A(I)(b), regardless of the number of children.

d) Family First Maintenance Services

Services to maintain the family intact following the provision of more intensive services are billable. These services are limited to the duration specified in the family's individual service plan, not to exceed 150 days.

1) Agency Counseling

Type Service Code		Document
3041	Family Maintenance Agency Counseling	CFS 1042-F

2) Individual Counseling - Service and Expenses

Type Service Code		Document
3042	Family Maintenance Individual Counseling - Service and Expenses	CFS 1042-F

3) Agency Advocacy

Type Service Code		Document
3043	Family Maintenance Agency Advocacy	CFS 1042-F

4) Agency Homemaker

Type Service Code		Document
3051	Family Maintenance Agency Homemaker	CFS 1042-F

5) Individual Homemaker

Type Service Code		Document
3052	Family Maintenance Individual Homemaker	CFS 1042-F

Instructions: If the family maintenance service is offered by the same provider program that offers intensive services, Agency Counseling contracts are paid at standard rates authorized by the Office of Contract Administration. If the Agency Counseling services are offered by another program of the agency under contract, the rate prevailing in the already existing counseling contract is paid. If an agency not under contract for intensive family preservation services offers family maintenance counseling services, the standard rates are paid. The Office of Contract Administration may authorize an exception to these conditions for sufficient cause, filed with that Office and approved in writing. Agency Homemaker contracts are paid at standard rates. For other services, rates are as negotiated, limited to the costs reasonable and necessary for the service.

e) Family First Project SAFE Service Payments

Type Service Code		Document
3048	Family Maintenance Counseling-Project SAFE	CFS 1042-F

Instructions: When Project SAFE services are paid from the Family First appropriation, service type 3048 is to be used. Such contracts are to be paid at the rates negotiated for this service, which may vary according to providers' reasonable and necessary costs.

f) Other Family First Payments - Appeal Awards

Family Preservation/Reunification Reimbursement for Extraordinary Mileage

Type Service Code		Document
3031	FPS Reimbursement/Extraordinary Mileage	CFS 1042-F
3032	FRS Reimbursement/Extraordinary Mileage	CFS 1042-F

Instructions: When a provider has successfully appealed extraordinary mileage costs incurred in the delivery of intensive Family First services in a widespread service area, service type codes 3031 and 3032 are used to reimburse the extraordinary costs. In this case monthly bills are analyzed to determine if miles that are driven for the purpose of providing direct or collateral services to clients exceed 10 miles per unit of service billed during that month. Mileage above ten miles per unit of service may be reimbursed at the mileage rate the Agency pays to its employees, not to exceed the mileage reimbursement rate set by the State of Illinois Department of Central Management Services.

Section 359.57 Payment for Norman Services

Type Service Code		Document
4001	Advance to Cash Assistance Providers	CFS 1042-N
4002	Shelter - Security Deposit	CFS 1042-N
4003	Shelter - First Month's Rent	CFS 1042-N
4005	Shelter - Repairs	CFS 1042-N
4006	Utilities - Previous	CFS 1042-N
4007	Utilities - Initial Costs	CFS 1042-N
4008	Food	CFS 1042-N
4009	Administration Fee	CFS 1042-N
4010	Housing Advocacy	CFS 1042-N
4011	Clothing	CFS 1042-N
4012	Furniture/Equipment	CFS 1042-N
4013	Transportation	CFS 1042-N
4014	Miscellaneous	CFS 1042-N
4015	Kitchen Appliances	CFS 1042-N
4016	Furniture Other than Beds	CFS 1042-N
4017	Major Cleaning / Extermination	CFS 1042-N

Instructions: Referrals for Norman Services are described in Procedures 300.120 and 302.385. When emergency services have been provided to clients who have been referred by the Department, providers will submit their claims to the Regional Norman Liaisons.

Section 359.58 Payments for Interpreter Services and Auxiliary Aids

a) Sign Language Interpreter Services

Type Service Code		Document
0411	Interpreter Services for Hearing Impaired	CFS 1042

Instructions: To pay for sign language interpreters for hearing impaired clients. To be used when conducting official Department business with any hearing impaired person who is receiving Department services or seeks to apply for services who has identified sign language as the preferred mode of communication. Also used to enable hearing impaired clients to receive other services such as counseling, homemaker, etc. as negotiated through contracts and agreements.

b) Foreign Language Interpreter Services

Type Service Code		Document
0412	Interpreter Service for Limited/Non English Speaking Clients	CFS 1042

Instructions: To pay for foreign language interpreters for limited/non-English speaking clients if a staff person who speaks the client's primary language is not available. To be used when conducting official Department business with limited/non-English speaking persons who receive Department services or seek to apply for services. Also to be used to enable Department clients to receive other services such as counseling, homemaker, etc. As negotiated through contracts and agreements and/or established regional protocols to access Interpreter Services.

c) Auxiliary Aids for Hearing Impaired Clients

Type Service Code		Document
0413	Auxiliary Aids for Hearing Impaired	CFS 932

Instructions: To pay for items as indicated in the case plan for hearing impaired clients, such as but not limited to: amplified phones, decoders which alert the hearing impaired person to phone calls, door bells, smoke or fire, baby crying, etc., closed caption television devices, or other equipment designed for the hearing impaired. Telecommunication Devices for the Deaf (TDDs) are available to the hearing impaired free of charge. Consult medical payment policy, Section 359.9 for the procurement of hearing aids which are reimbursable only at the actual cost.

INDEPENDENT LIVING ARRANGEMENTS EDUCATION & TRANSITIONAL SERVICES

Section 359.60 Payments for Supervised Independent/Transitional Living Placement Contracts

If the placement relates to any of the following placements: Institutional Residential Care, Child Welfare Group Homes, or Supervised Independent Living Substitute Care programs, the agency must complete **CFS 906 Placement/Payment Authorization Form** immediately after placement. The agency must then transmit the **CFS 906** information via telephone call or fax to the appropriate region. The appropriate region must receive a call or fax within two working days of the client's placement or discharge. Retroactive payments will not be authorized for more than two days from the time the telephone call or fax is received by the appropriate region. For payment to be authorized, placement in a supervised independent/transitional living program must have the prior approval of the CAYIT.

Type Service Code		Document
0204	Supervised Independent Living Placement	CFS 906-1
0215	Supervised Independent Living Placement	C-13
7204	Medicaid Supervised Independent Living Placement	CFS 906-1
0268	Transitional Living Program (TLP)	CFS 906-1
7268	Medicaid Transitional Living Program (TLP)	CFS 906-1

Instructions: Payment may be made for supervision of youth 16 through 20 years of age in independent or transitional living arrangements by licensed child welfare agencies as negotiated by contract.

Section 359.61 Payments for Refugee Assistance Supervised Independent Living Placement

Type Service Code		Document
0208	Refugee Assistance Supervised ILA	CFS 906-1

Instructions: Monthly board payment for youth 16 through 20 years of age varies based on child's income during the month. As negotiated by contract.

Section 359.62 Payments for Employment Incentive Program

Type Service Code		Document
0701	Youth in Employment Program (monthly grant) (No new clients effective 01/01/06)	CFS 906
0702	Employment Incentive Program – Initial Expenses	CFS C-13
0703	Initial Month-Youth in Transition (No longer used)	CFS C-13

0708	Youth in Employee Incentive Program (Central Office Use only – effective 01/01/06)	CFS C-13

Instructions: Payment may be made to adolescents 17 through 20 years of age who are admitted into the Employment Incentive Program in accordance with Procedures 302, Services Delivered by the Department, Appendix F. See Appendix A(III)(a) for amounts. Youths in employment may be in another paid board living arrangement while participating in the DCFS Employment Incentive Program.

Additionally, initial expenses (0702) related to establishing employment may be partially subsidized by the Department. See Appendix A(III)(a) for amounts. The youth will present an itemized list of necessities to the worker who will review it and who **may** authorize a payment not to exceed the maximum as indicated in Appendix A of these procedures.

Medical and dental needs shall be handled in accordance with section 359.90, Medical Care.

The approval of the Office of Education and Transitional Services (OETS) is needed for payment documents.

Section 359.63 Payment for Youth in College / Vocational Training Program

Type Service Code		Document
0720	Youth in College / Vocational Training Program (monthly grant)	CFS 906
0721	Youth in College / Vocational Training One Time Only Initial Expenses	CFS C-13
0725	Youth in College (Central Office Use Only)	CFS 906

Instructions: Initial expenses (0721) related to setting up a household will be partially subsidized by the Department. See Appendix A(III)(a) for amounts. Youths in college may not be in another paid board living arrangement while participating in the DCFS Youth in College / Vocational Training Program.

Medical and dental needs shall be handled in accordance with Section 359.90, Medical Care.

The approval of the Office of Education and Transitional Services (OETS) is needed for payment documents.

If the youth is still in the program upon reaching the age of 21, the medical card is terminated. The monthly grant payment to the youth may continue past the age of 21 for the duration of the youth's eligibility in the program.

Section 359.64 Payment for Department Scholarships

Type Service Code		Document
0801	Department Scholarship Living Expenses (monthly grant)	CFS 906
0802	Dept. Scholarship-One time Only Initial Expenses	CFS C-13
0806	Department Scholarship (Central Office Use Only)	CFS 906

Instructions: An initial one-time only payment (0802) up to the amount in Appendix A (III)(a) will be authorized for expenses/supplies necessary to establish independence when the youth becomes his/her own payee. Scholarship youth will then receive up to the amount in Appendix A (III)(a) per month for room and board while attending college or university (0801). Scholarship youth may not be in another paid board living arrangement while participating in the DCFS Scholarship Program. See Rules 312, DCFS Scholarship Program, and Appendix I of Procedures 302, Services Delivered by the Department for a more complete description of the Department's scholarship program.

The **CFS 438, Scholarship Application** is used to apply for a scholarship. The Scholarship Committee selects the scholarship recipients. Approval of the Office of Education and Transitional Services (OETS) is needed for payment documents.

The monthly grant payment and medical card will continue for youth in the program for the youth's duration of eligibility in the program (i.e., this may be past the age of 21 years old).

Section 359.65 Payment for Transitional Living Program Support Services (TLP)

The following items apply generally to all **TLP** support services. The type service code, instructions and authorized rates for each individual service will be listed separately.

Age Level: Ages 14-21

Approval Level: Office of Education and Transition Services (OETS) for payment documents.

Preconditions: Limited to DCFS wards residing in private or relative foster homes.

Payment documents: CFS 1042 - for service detail
C-02 - for individual contractors
C-13 - to be prepared by OETS
CFS 932

a) TLP Basic Life Skills Training

Type Service Code		Document
2001	TLP Basic Life Skills Training	CFS 1042

Instructions: Group or individual instruction for youth in basic life skills may be purchased from individual trainers or organizations. Payments are made at a negotiated hourly rate for hours of instruction. The hourly rate would reflect preparation time needed and includes office/administrative expenses, supplies, snacks, and classroom instruction.

b) TLP Vocational Training Employment

Type Service Code		Document
2002	TLP Vocational Employment Training	CFS 1042

Instructions: Vocational training classes, job coaches, subsidized employment, sheltered workshops, and trade school tuition may be purchased for eligible youth. Tuition, grant amounts, or rates of pay will be determined by negotiated contracts or established community fee standards.

c) TLP Life Skills Coordination - Agency

Type Service Code		Document
2003	Life Skills Coordination - Agency	CFS 1042

Instructions: Payment may be made for life skills instructor services through an agency contract which includes supporting youth to achieve objectives and goals which will enhance the youth's maturity and ability to function as an independent, self-sufficient individual. As negotiated by contract.

d) TLP Life Skills Coordination - Individual

Type Service Code		Document
2004	Life Skills Coordination - Individual	CFS 1042

Instructions: Payment may be made for life skills instructor services purchased from an individual. Payment will not be made for supplies, meals, or activities outside the realm of the contract. Payment may be made at the negotiated hourly rate for the actual hours on assignment. Life skills instructors shall not be assigned responsibilities that cause them to work more than 40 hours per week unless special contract approval has been received from the Director.

Life skills instructors who work by the hour will be paid at the hourly rate negotiated by the Deputy Director supervising Education and Transition Services.

e) TLP Life Skills Instructor/Coordinator - Training

Type Service Code		Document
2005	Life Skills Instructor/Coordinator - Training	CFS 1042

Instructions: Payment may be made to providers of training to life skill instructors at negotiated hourly rates for actual hours of work, or at reasonable prices per deliverable. A program plan shall detail the services to be provided, the target group receiving the services, the means to evaluate the success of the training, and the method of payment. The payment provisions shall detail hours of work and/or deliverables to be received. A budget outlining costs for services and expenses is required. Reasonable expenses directly related to the services may be compensated. Reimbursement for costs of travel shall be in accordance with the Department of Central Management Services (CMS) and DCFS travel regulations.

f) TLP Life Skills Instructor/Coordinator - Medical Exam

Type Service Code		Document
2006	Life Skills Instructor/Coordinator - Medical Exam	CFS 1042

Instructions: Life skills instructors may be reimbursed for the required physical examinations, tuberculin skin test, and, if indicated, chest x-ray and other laboratory test prescribed by the physician and/or Department. Life skills instructors are to be encouraged to use the benefits of private health coverage if covered by existing insurance policies.

Up to **$75.00** is allowed per examination. Bills **over $75.00** must have prior approval in writing from the Regional Administrator and must be attached to the bill. If the life skills instructor is to be reimbursed for the physical, such expenses are to be included in the reimbursable expense maximum of the contract.

g) TLP Life Skills Instructor Travel

Type Service Code		Document
2007	Life Skills Instructor/Coordinator - Travel	CFS 1042

Instructions: Payment will not be made for supplies, meals or activities outside the realm of the contract. Payment may be made at the negotiated hourly rate for the actual hours on assignment. Reimbursement for the cost of travel shall be established by rate and stated in the contract. Life skills instructors using their own cars for transportation shall have a driver's license and proof of public liability coverage and property damage in their insurance policies. Proof shall be available in the contract file. Recommended coverage is $100,000 each person, $300,000 each accident, and $25,000 for property damage or the minimum required by law.

h) TLP Caregiver/Caseworker Training

Type Service Code		Document
2008	Caregiver/Caseworker - Training	CFS 1042

Instructions: Contracts for training and for recruitment of foster parents may be negotiated with an individual or agency demonstrating expertise in the field. The cost of registration fees, training sessions and related travel costs, including babysitting for the children of individual DCFS foster parents, may be reimbursed as negotiated by contract via voucher if adequate documentation (receipts showing proof of expenditure by the foster parents) is attached to the voucher.

i) TLP Counseling Agency

Type Service Code		Document
2010	TLP Counseling - Agency	CFS 1042

Instructions: Payment may be authorized for counseling purchased from an agency in accordance with a negotiated contract and with prior approval of the TLP Administrator.

j) TLP Counseling - Individual

Type Service Code		Document
2011	TLP Counseling - Individual	CFS 1042

Instructions: Counseling is available with approval of the TLP Administrator. Counseling purchased from an individual in accordance with a negotiated contract, including services and expenses, as negotiated by contract.

k) TLP Youth Learning Incentive

Type Service Code		Document
2012	TLP Youth Learning Incentive	CFS 1042

Instructions: Youth may receive up to the amount in Appendix A (III) (b) as an incentive to participate in and complete a basic life skills training course. Payment may be made through the basic skills training contract and paid out per class session or at other less frequent intervals.

l) TLP School Expense

Type Service Code		Document
2014	TLP School Expenses	CFS 1042

Instructions: Payment may be allowable as required and accompanied by statement of need from school. Supplies may include material for wood shop class, industrial arts supplies, home economics supplies, lab supplies, etc.

m) TLP Graduation Expense

Type Service Code		Document
2015	TLP Graduation Expenses	CFS 1042

Instructions: Payment may be made for all items such as pictures, yearbook, cap and gown rental, class ring, new clothing for graduation and other fees. See Appendix A (III)(b) for amount maximum.

n) TLP Tuition

Type Service Code		Document
2016	TLP Tuition	CFS 1042

Instructions: Tuition may be paid for eligible youth to attend special classes that would assist them in completing a high school degree or equivalency. Payment will be based on the rates charged by the schools or training centers.

o) TLP Tutoring

Type Service Code		Document
2017	TLP Tutoring	CFS 1042

Instructions: Purchase Authorization must be accompanied by a written recommendation and tutor approval from the classroom teacher. If payment is expected to reach or exceed $9,999 to a single provider, the Regional Contract Unit should be contacted regarding the need for a contract. For payments to a single provider that are less than $9,999, the vouchers are to be submitted to the Business Manager for processing. The prevailing community rate should be used.

p) TLP Field Trips

Type Service Code		Document
2018	TLP Field Trips	CFS 1042

Instructions: Purchase Authorization for payment must be accompanied by recommendation from the TLP Administrator. See Appendix A(III)(b) for amounts.

q) TLP Youth Transportation - Employment

Type Service Code		Document
2019	TLP Youth Transportation - Employment	CFS 1042

Instructions: Transportation expenses may be paid for a youth to travel to and from work at the most economical rates. Requests for payment are to be submitted by the vendor. If foster parents must provide transportation, reimbursement may be made in accordance with CMS and DCFS Travel Regulations.

r) TLP Youth Transportation - Education

Type Service Code		Document
2020	TLP Youth Transportation - Education	CFS 1042

Instructions: Staff should assure that Department wards are provided transportation by local school districts consistent with the provision in Article 29 of the School Code of Illinois.

If special equipment is needed, a rental arrangement is preferred. If, however, purchase of said equipment is more economical, Department purchasing rules must be followed. Purchased items remain with the child.

s) TLP Youth Transportation - Recreation

Type Service Code		Document
2021	TLP Youth Transportation - Recreation	CFS 1042

Instructions: Transportation expenditures are allowable only for transportation to and from recreational activities by the most economical means. Requests for payment are to be submitted by the vendor. If foster parents must provide transportation by personal automobile, reimbursement must be made in accordance with the CMS and DCFS Travel Regulations.

t) TLP Youth Transportation - Visitation

Type Service Code		Document
2022	TLP Youth Transportation - Visitation	CFS 1042

Instructions: Payment may be made for transportation expenses to the home of former foster parents, mentors or relatives when authorized **prior** to travel and the past relationships are to be maintained. Workers' expenses are paid by travel voucher **(C-10)** accompanied by receipts. Non-state employees' expenses are payable via **(C-13)** from the Region's contractual line. Travel expenses must be made in accordance with the CMS and DCFS Travel Regulations.

u) TLP Youth Transportation - Other

Type Service Code		Document
2023	TLP Youth Transportation - Other	CFS 1042

Instructions: Transportation expenses may be paid for a youth to travel for reasons other than employment, recreation, education, and visitation only with prior approval of TLP Administrator, by the most economical means. Requests for payment are to be submitted by the vendor. If the foster parent must provide transportation, reimbursement may be made in accordance with CMS and DCFS Travel Regulations.

v) TLP Travel Reimbursement - Volunteer

Type Service Code		Document
2024	TLP Youth Reimbursement - Volunteer	CFS 1042

Instructions: Volunteers working with TLP youth may be reimbursed for travel related to their training costs and direct service to youth. Reimbursement for the cost of travel shall be in accordance with the Department of Central Management Services (CMS) and DCFS travel regulations. Reimbursement for travel time and travel costs shall be part of the contract. Reimbursement will be made for reasonable amounts spent for bus fare, or taxi fare where no bus transportation is available. Volunteers using their own cars for transportation shall have a driver's license and proof of public liability coverage and property damage in their insurance policies. Proof of this shall be available in the regional contract file. Recommended coverage is $100,000 each person, $300,000 each accident, and $35,000 for property damage or the minimum required by law. Travel reimbursement may be made in accordance with CMS and DCFS Travel Regulations.

w) TLP Youth Activity Fees

Type Service Code		Document
2025	TLP Youth Activity Fees	CFS 1042

Instructions: With prior approval and a request from a youth, payment for recreation admissions, entertainment tickets, or other cultural enrichment activities may be made at the prevailing rate.

x) TLP Youth Membership Fees

Type Service Code		Document
2026	TLP Youth Membership Fees	CFS 1042

Instructions: Payment may be made for membership fees and may include Boy Scouts, Girl Scouts, 4-H, YMCA and other like groups. Membership fees may also cover cost of swimming passes and required supplies.

y) TLP Youth Retreats

Type Service Code		Document
2027	TLP Youth Retreat	CFS 1042

Instructions: Payments may be made for youth to travel to attend retreats or youth clubs. Contracts for retreats or youth clubs should specify the program to be offered and should include transportation, meals, and lodging for participants, as negotiated by the contract. Travel expenses shall be in accordance with CMS and DCFS Travel Regulations.

z) TLP Camp Fees

Type Service Code		Document
2028	TLP Camp Fees and Supplies	CFS 1042

Instructions: Payment may be authorized for youth in transitional living when deemed essential for the child's social development. Camp includes day camp. Payment may be made for camp supplies for activities that are not included in the camp fee. See Appendix A(III)(b) for maximum amounts per year per child for camp fees and maximum amounts per year for camp supplies.

aa) TLP Youth Handbooks

Type Service Code		Document
2029	TLP Youth Handbooks	CFS 1042

Instructions: Payment may be made for supplies, photographs, document reproduction, and other expenses related to the completion of a life handbook for a youth. Receipts for expenses are required for reimbursement.

bb) TLP Work Clothes and Supplies

Type Service Code		Document
2030	TLP Work Clothes and Supplies	CFS 1042

Instructions: The need for work clothing and/or supplies must be documented by written recommendation from the caseworker. Purchase Authorizations must be accompanied by the list of required items. Only items required for work should be purchased. See Appendix A(III)(b) for amounts.

cc) TLP Future Use Services

Type Service Code		Document
2031	TLP Future Use Services	CFS 1042

Instructions: Case management services may be purchased for individual youth from private agencies or organizations pursuant to a contract which details the case management service and expenses to be covered, as negotiated by the contract.

dd) TLP Future Use

Type Service Code		Document
2032	TLP Future Use	CFS 1042

Instructions: Case management services may be purchased for individual youth from qualified individuals pursuant to a contract that details the case management services and expenses to be covered, as negotiated by the contract.

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CHILDREN'S PERSONAL AND PHYSICAL MAINTENANCE (CPPM)

Section 359.70 Payments for Children's Clothing

a) Initial Placement Clothing/Personal Hygiene Expenses

Type Service Code		Document
1201	Initial Placement Clothing/Personal Hygiene Expenses	CFS 932
	See Appendix A(IV) for amounts	CFS 1042

Instructions: Initial placement clothing is a one-time only expense to be authorized for a child in his first out-of-home placement at the time the case is opened or within six months of the time the case is opened. Purchase of such clothing is not intended to completely outfit the child since the monthly payment rate provides for replacement clothing.

Caretakers for Department supervised cases will be issued CFS 932s and are allowed to take advantage of both sales and seasonal needs; however, regions must make sure, if several purchase authorizations are used, that the total expenditure does not exceed the maximum allowable.

Initial personal hygiene items may also be authorized for a child in his first out-of-home placement at the time the case is opened. Purchase of such items is intended to assist a child in his personal hygiene needs and can include but is not limited to such items as a toothbrush, toothpaste, hairbrush/comb/pick, deodorant, feminine hygiene items. These purchases may also cover personal items for infants such as bottles, baby powder, baby oil, disposable diapers, etc. **Cosmetics, perfume, jewelry, hairdryers, etc., are not allowable**.

Purchase of Service foster care agencies are responsible for assessing the clothing/personal hygiene needs of the child and making the initial purchase. The POS agency must submit a monthly CFS 1042, Billing Summary, itemizing by the child's name and case ID, the costs incurred, with receipts attached to support the costs, to the Department of Children and Family, The Central Office Client Payment Unit, 406 E. Monroe, Station #438, Springfield, IL 62701.

b) Replacement Clothing/Personal Hygiene Expenses

Type Service Code		Document
1202	Replacement Clothing	CFS 932 or CFS 1042
1205	Unmarried Mothers Clothing - Wards	CFS 932 or CFS 1042

Instructions: Replacement clothing costs, other than those included in the child's living arrangement cost, for which the Department is responsible are those due to destruction of clothing by fire, flood, or the child's willful destruction; because of unsuitability of clothing due to health or medical reasons such as extraordinary weight gains or losses, excessive

growth, or damage done to clothing to accommodate casts or braces; when special items are required as a result of residential placement or when a youth enters an independent living program, such as YTP or YCP. Replacement clothing may also be purchased for wards who have been returned home for an extended period of time and returned to placement. Wards who are in a DOC or detention facility may be issued a clothing voucher at the time of discharge from the facility. See Appendix A(IV) for amounts. Unmarried mothers may be issued a clothing voucher for maternity clothes. See Appendix A(IV) for amounts. In all cases, the reason for replacement clothing must be noted on the purchase authorization. The approval of the Regional Administrator or designee is needed for replacement clothing.

When a child or youth is placed in an emergency shelter or a youth stabilization program, necessary replacement clothing may be purchased at the discretion of the facility or program. Appropriate items may be reimbursed up to the maximum amount allowed by age (see Appendix A, Section IV).

Aside from the above situations, replacement clothing is the responsibility of the foster home, the private agency, or the residential facility. If the child's wardrobe does not appear to be adequate, the child's worker shall inform the caregiver of this fact in writing. **The worker shall also advise the caregiver that if he or she fails to replenish the child's wardrobe within 30 days, the Department will replace the clothing and the amount of the purchase authorization will be deducted from the future payments to the foster parent, the private agency or the residential facility.**

To ensure that this process is observed, the purchase authorization should clearly spell out that this is replacement clothing, which should be deducted from a particular caretaker's payment. The name of the child and the caretaker should be noted. This purchase authorization should be scheduled separately or flagged by means of a cover memo directed to the attention of the Central Office Client Payment Unit, 406 E. Monroe, Station #438, Springfield, IL 62701. Upon receipt of *this flagged voucher*, the Board Unit will process a credit to be taken against the future payment to the caretaker in question in the amount of the clothing purchase authorization.

The maximum amount allowed for replacement clothing is the same as the amount allowed for initial placement clothing. See Appendix A (IV).

Section 359.71 Payments for Financial Assistance to Foster Parents

a) Financial Assistance to New Foster Parents

Type Service Code		Document
0128	Financial Assistance to New Foster Parents	CFS 932

Instructions: Financial assistance can be provided to new foster families who will experience cash-flow problems in order to meet the needs of the children placed in their care. Purchase authorizations are to be issued only after all other alternatives have been considered and rejected. In all cases, receivables are to be entered against future foster care payments. To ensure that this process is observed, the purchase authorization should clearly spell out that this is an expense which will be deducted from a particular caretaker's payment. The name of the child and the caretaker should be noted. This purchase authorization should be scheduled separately or flagged by means of a cover memo directed to the attention of Financial Management, 406 E. Monroe, Station #412, Springfield, IL 62701. *Upon receipt of this flagged voucher,* the Collections Unit will process a credit to be taken against the future payment to the caretaker in question in the amount of the clothing purchase authorization. The approval of the Regional Administrator or designee is needed for the payment document. The amount shall not exceed the Basic Board component of the authorized monthly rate. See Appendix A(I)(b) for Rates for Department Boarding Homes.

b) Foster Home Infant Equipment

Type Service Code		Document
1315	Foster Home Infant Care Equipment	CFS 932 CFS 1042

Instructions: DCFS supervised cases may have a purchase authorization issued to a foster or relative home for infant care equipment for a specific child age 2 and under. The foster parent must sign the **Infant Care Equipment Grant Application (CFS 932-C)** and return a completed **Infant Care List (CFS 932-D)** for the appropriate items. Purchase of Service Foster Care Agencies are responsible for assessing the need and making the purchase for the cases they have been assigned case management. The purchase must be for a specific child age 2 and under. The POS agency must submit a CFS 1042, Billing Summary, itemizing by the child's name and case ID, the costs incurred, with receipts attached to support the costs, to The Department of Children and Family Services, The Central Office Client Payment Unit, 406 E. Monroe, Station 438, Springfield, IL 62701.These payment procedures are to be used only when the lack of appropriate equipment is a barrier to the placement of an infant in a foster or relative home. The relative or foster parent should transfer the equipment to the subsequent placement. See Appendix A (IV) for amounts.

c) Home of Relative Compliance Assistance

Type Service Code	Document
0139	CFS 932 or CFS 1042

Instructions: Payment is to be processed through the DCFS region for both POS and DCFS relative homes. The following expenses may be paid to assist a relative caregiver attain foster home licensure:

- Travel costs and child care expenses associated with getting fingerprinted; and,

- The cost of a child's bed when the relative caregiver cannot afford the cost of purchase and the lack of a bed will disrupt placement, prevent siblings being placed together or prevent foster home licensure.

d) Reimbursement for Home of Relative Licensing Medical Exams

Type Service Code		Document
1123	HMR Licensing Medical Exam Reimbursement	CFS 1042

Instructions: Reimbursement of required medical exam costs for all family members in a household providing relative foster care services attempting to become licensed **when other options for payment are not available as verified and documented by the licensing worker or child(ren)'s caseworker**. Maximum reimbursement amounts for adult household member is $250 and for children under the age of 18, $150.

POS agencies should reimburse relative foster parents directly and then seek reimbursement from DCFS by submitting the CFS 1042, Billing Summary, itemizing by relative foster parent's name and provider ID, the medical exam costs incurred for all household members. Corresponding receipts must be attached to support the costs to the POS' respective DCFS regional business office.

DCFS relative foster parents shall be assisted by either the licensing worker or the child(ren)'s caseworker in completing a CFS 1042 Billing Summary, indicating their name and provider ID, the medical exam costs incurred for all household members with receipts attached to support the costs to their respective DCFS regional business office.

Medical examinations are required of all foster family home applicants and members of their household for initial license. Adults must have an actual physical. Children's health exam records suffice if updated within the prior 12 months. Please see Procedures 402.14, Health of Foster Family, for additional information.

Section 359.72 Allowance for Children in Facilities for which the Department does not make Board Payments

a) Personal Allowances for Children in Title XIX Certified Facilities

Type Service Code		Document
0207	DHS, DPH Institution Allowance	CFS 906
0216	Cuban-Haitian Refugee	CFS 906
0217	Other Refugee	CFS 906

Instructions: A Title XIX Certified Facility is a facility that the Department of Public Health has certified as meeting specifications required by Title XIX of the Social Security Act. This commonly means a nursing home in which children are receiving intermediate or skilled nursing care. This type of facility can also include DHS facilities. In the case of a DHS facility, the child must be in a ward or bed that has been designated as Title XIX

certified, which means the child is receiving intermediate or skilled nursing care even though the entire facility is not devoted to that type of care.

If the amount accumulates to more than $50 in a child's account at the facility, any excess funds will be deposited in an interest bearing account for the child's use. If a child in a Title XIX certified facility needs clothing, it shall be handled on an as needed basis. Follow instructions contained in the section on Replacement Clothing.

b) Personal Allowances and Clothing for Children in Non-Title XIX Facilities (Includes DHS, Department of Corrections, Detention Facilities, School for the Deaf, School for the Visually Impaired, Children's Hospital School, Illinois Children's School and Rehabilitation Center, and other State Approved Facilities).

Type Service Code		Document
0207	DHS, Institution Allowance	CFS 906
0218	Allowance – Detention and Correction Facility	CFS 906
0216	Cuban-Haitian Refugee	CFS 906
0217	Other Refugee	CFS 906

Instructions: Personal allowances and clothing monies may be paid for wards in Non-Title XIX certified facilities or in non-Title XIX certified beds on an ongoing monthly basis when there are no other funds available to provide for these expenses. A personal allowance may be paid to a ward being held in a detention facility when no other resources are available. See Appendix A(IV) for amount.

For the maximum amount for personal allowance and clothing for wards in Non-Title XIX facilities or for wards in detention facilities, see Appendix A(IV) for amounts.

Section 359.73 Payments for Camping Expenses for Wards in Substitute Care

The payment items listed below are limited to children who are in DCFS supervised foster care placements, Youth In College, youth in the scholarship program, or DHS facilities. For all other placement types, these items are included in the contractual rate. The maximum amounts allowable for the items listed below are contained in Appendix A.

a) Camp Fees

Type Service Code		Document
1505	Camp Fees – Wards Reimbursement to Foster Parents or Relative Caretaker	CFS 932
	Direct Payment of Provider	C13-1

Instructions: Camp fees may be authorized for children in placement to promote the child's healthy social development. Camp includes day camp. See Appendix A(IV) for amounts.

b) Camp Clothing

Type Service Code		Document
1203	Camp Clothing for Wards/Required	CFS 932 or C13-1

Instructions: The need for clothing must be documented in the form of a written recommendation from the camp and kept on file at the Regional Office. Only items required by the camp should be purchased. See Appendix A (IV) for amounts.

c) Camp Supplies

Type Service Code		Document
1507	Camp Supplies - Wards	CFS 932 or C13-1

Instructions: Camp supplies may be authorized for activities which are not included in camp fee. See Appendix A (IV) for amounts.

d) Camp Transportation

Type Service Code		Document
1404	Camp Transportation for Wards	CFS 932 or C13-1

Instructions: Transportation expenditures are allowable only for transportation to and from camp at the prevailing rate. Requests for payment to be submitted by the vendor. If foster parents must provide transportation by personal automobile, reimbursement may be made in accordance with CMS and DCFS Travel Regulations.

e) Supervised Overnight Camping - Wards

Type Service Code		Document
1509	Supervised Overnight Camping-Wards	CFS 932 or C13-1

Instructions: Payment may be made for overnight summer camping experience to Department wards, ages 7 through 16, including programs involving swimming, camp craft, nature hiking and arts and crafts. See Appendix A(IV) for rate.

Section 359.74 Payments for Children's Cultural Enrichment

The payment items listed below are limited to children who are in DCFS supervised foster care placements, Youth In College, Youth In Scholarship, or DHS facilities. For all other placement types, these items are included in the contractual rate.

a) Recreational and Artistic Lessons

Type Service Code		Document
1501	Art, Acting, Dancing, Music and Athletic Lessons	CFS 932 or C13-1

Instructions: Payment to include, but not limited to, art, acting, dancing, music, athletic instruction, may be made at the prevailing community rate.

b) Musical Instrument Rental/Purchase

Type Service Code		Document
1502	Rental	CFS 932 or C13-1
1503	Purchase	CFS 932 or C13-1

Instructions: When musical instruments must be purchased, a used instrument shall be considered prior to purchasing a new one. Purchase should be considered only for a child who has maintained an interest for six months. The instrument becomes the property of the child. Prevailing community rental rate, including reasonable insurance charges at current market rate may be paid. See Appendix A(IV) for maximum amounts.

c) Recreational Membership Fees and Equipment

Type Service Code		Document
1504	Membership Fees and Related Equipment	CFS 932 or C13-1

Instructions: This payment item includes Boy Scouts, Girl Scouts, 4-H, YMCA and other similar groups. This may also cover cost of swimming passes and required supplies. The amount is as required at prevailing rate.

Section 359.75 Payments for Children's Education Expenses

The payment items listed below are limited to children who are in DCFS supervised foster care placements, Youth In College, youth in the scholarship program, or DHS facilities. For all other placement types, these items are included in the contractual rate. POS agencies may be reimbursed for high school graduation expenses.

a) Books and School Rental Fees/Milk Fees

Type Service Code		Document
1301	Book and School Fees/Milk Fees	CFS 932 or C13-1

Instructions: Illinois State Board of Education (ISBE) is responsible for public and private elementary or secondary school expenses for children in residential care attending school (on-grounds or local) under the jurisdiction of the local school district. Additionally, payment for milk fees may be authorized when the school does not participate in the milk reimbursement program. In addition, ISBE has issued regulations concerning the issuance of waivers of school fees for children whose parents are unable to afford them, including but not limited to children eligible for free lunches or breakfasts under the Federal School Lunch Program. Under the regulations, school districts are required to provide for the free loan of required textbooks and instructional materials to these children. Since DCFS wards are eligible for the Federal School Lunch Program, DCFS wards are eligible for waivers for required textbooks and instructional materials.

Waiver of school fees other than those for textbooks and other instructional materials is discretionary. Staff need to check with the local school district to determine what other fees are included in their waiver policy.

b) Summer School Fees

Type Service Code		Document
1301	Book and School Fees	CFS 932 or C13-1

Instructions: Staff shall ask the school district to waive fees for wards in summer school. If the school district waiver policy does not include summer school fees and the district refuses to pay, the Department will bear the cost as required.

c) Post Secondary Education Fees

Type Service Code		Document:
1301	Book and School Fees	CFS 932 or C13-1
1303	Tuition for Trade Schools	CFS 932 or C13-1

Instructions: Payment will be made for post secondary education (junior college, college, including trade schools, etc.) only. These fees may include laboratory fees, library fees, activity fees, supplies as recommended by the school, etc. With the exception of trade schools, tuition is not included in the definition of fees.

d) School Supplies

Type Service Code		Document
1307	Regular School Supplies	CFS 932 or C13-1
1310	Board Payment School Supplies (For DCFS supervised foster care placements only)	

Instructions: An automatic payment will be made in August, based on the child's July 31 placement, via the board system for children in DCFS supervised foster care placements. CFS 906s that are processed after that, to change living arrangements, will automatically be adjusted. If a child received payment for school supplies based on July 31st placement, no additional school supplies fee may be paid. Any placement after July 31st in which a child has not received school supplies payment may be made from CPPM via service code 1307.

These payments are allowable once per year at the beginning of school for such supplies as pens, pencils, notepaper, notebooks, calculators, pocket dictionaries, crayons, glue, erasers, rulers, etc. Routine ongoing supplies are to be paid from the board rate. To be eligible for the payment, the child must be 5 years old prior to December 1. Children under 5 are eligible for the payment if in special education. In these cases, payment must be made by voucher **CFS 932, Purchase Authorization**. See Appendix A(IV) for amounts.

e) Required Special Class Supplies

Type Service Code		Document
1307	Regular School Supplies	CFS 932 or C13-1

Instructions: Payments for special class supplies allowable as required. A statement of need from school must be kept on file in the Regional Office. The supplies may include material for wood shop class, industrial arts supplies, home economics supplies, lab supplies, etc. Staff should check with the school district to determine whether any of these items are included in the district's waiver policy; if not, they may be purchased at reasonable cost.

f) Summer School Supplies

Type Service Code		Document
1306	Summer School Supplies	CFS 932 or C13-1

Instructions: Payments may be made for summer school supplies such as pens, paper, notebooks, etc. See Appendix A(IV) for amounts.

g) Gym Shoes/Equipment

Type Service Code		Document
1309	Required Gym/Athletic Equipment	CFS 932 or C13-1

Instructions: Items required to participate in school gym classes may be paid. Statement of need from school shall be kept in the case file. Amount is as required.

h) School Athletic Insurance

Type Service Code		Document
1308	Athletic Insurance	CFS 932 or C13-1

Instructions: School athletic insurance is to be purchased only if required by school for athletic participation. It should be pointed out to the school that all wards are covered by Medicaid, and this coverage would take the place of school insurance. If the school will not accept Medicaid, a supporting document must be submitted by the school with the purchase authorization as documentation for payment and kept in the case file. See Appendix A(IV) for amounts.

i) Graduation Expenses

Type Service Code		Document:
1302	Graduation Expenses for DCFS Supervised Youth	CFS 932 or C13-1
	Graduation Expenses for POS Supervised Youth	CFS 1042

Instructions: The youth must be in junior or senior year of high school for payment for all graduation items including pictures, yearbook, cap and gown rental, class ring, new clothing for graduation and related other fees. See Appendix A(IV) for rate.

In order for POS agencies to be eligible for reimbursement of high school graduation expenses, a youth must be in his/her junior or senior year in high school for reimbursement of a class ring. A youth must be in his/her senior year in high school for reimbursement of graduation items such as pictures, yearbook, cap and gown rental, and new clothing for graduation and other related fees. POS agencies are expected to purchase the necessary approved items, and not expect foster parents to cover the costs. Reimbursement requests should be submitted by POS providers to Central Office Payment Unit in Springfield, itemized by the child name and case id number the costs incurred, with receipts attached to support the costs. Any amounts exceeding the maximum allowed per child (see Appendix A, Section IV for maximum allowable amount) must be absorbed by the agencies nonrecurring expenses as outlined in the contract. Submit CFS 1042 billings to:

Central Office Client Payment Unit
406 E. Monroe, Mail Station #438
Springfield, IL 62701

j) School Trips

Type Service Code		Document
1305	School Trips	CFS 932 or C13-1

Instructions: The recommendation from the school must be kept on file in the case file. See Appendix A(IV) for rate.

k) Public Transportation for School

Type Service Code		Document
1401	School Transportation	CFS 932 or C13-1 CFS 1042

Instructions: Staff should assure that Department wards are provided transportation by local school districts consistent with the provision in Article 29 of the School Code of Illinois. Most school districts provide transportation for students who live one and one-half miles or more from their school and who live one and one-half miles or more from public transportation, regardless of the distance the student is transported by public transportation. Local school districts may provide free transportation for any student who resides within one and one-half miles from the school where conditions are such that walking constitutes a serious hazard to the safety of the student due to vehicular traffic. The determination as to what constitutes a serious safety hazard is made by the Illinois Department of Transportation based on an application filed by the local school district. Workers shall collaborate with local school districts regarding the provision of these services.

The caseworker shall exhaust all options of reimbursement for school transportation expenses through the school district. If a DCFS ward is not eligible for free school transportation provided by the school district and DCFS staff determine that school transportation services are appropriate for that ward because:

A) The child's placement address is outside the school district boundaries; or
B) The school district does not or can not provide transportation; or
C) The school district does not or will not reimburse the foster parent for the school transportation expenses.

Such services shall be paid by the Department by submitting a reimbursement in **CFS 1042, Billing Summary** including the documents reflecting the rejection of reimbursement by the school board and the child's education plan to the Central Office Client Payment Unit at 406 E. Monroe – Station #438, Springfield, Illinois 62701.

The Department may also include payments of school transportation for disabled children,* for children attending special schools such as vocational and summer schools and for other educational situations in which public (bus) transportation is required. If special equipment is needed, a rental arrangement is preferred. If, however, purchase of said equipment is more economical, Department purchasing rules must be followed. Purchased items remain with the child.

*Students receiving special education services may have transportation services included in their Individualized Education Plan (IEP). If transportation services are included in the student's IEP, they are to be provided by the school district free of charge regardless of the student's proximity to the school or to public transportation.

l) Tutoring

Type Service Code		Document
1304	Tutoring	CFS 932 or C13-1

Instructions: The tutor must be approved by the classroom teacher and the Regional Educational Liaison. The written recommendation must be submitted with the request, with a copy kept in the case file.

Tutoring will be paid for by the Department only after other sources (e.g. local school district) have been exhausted. If a tutoring request to a source outside of the Department is pending and tutoring services are needed immediately, the Department may purchase tutoring services pending resolution of the request.

Tutoring may be provided for wards in situations including but not limited to the following:

A) The child is behind in grade levels/achievements;
B) The child currently has one or more failing grades;
C) Tutoring is recommended by the school on **CFS 407, School Report Form**;
D) The child has been retained one or more years; or
E) The child has received one or more class/subject deficiency reports.

m) Post Secondary Preparation Fees

Type Service Code		Document:
1311	Post Secondary Preparation Fees	CFS 932 or C13-1

Instructions: Payments may be made for wards in high school for fees related to preparing for college. Examples of such fees include ACT/SAT tests and college/vocational school application fees. Payment for ACT/SAT tests may be made for the actual cost of the test both in the child's junior and senior year in high school. Payment may be made for college/vocational school application fees not to exceed the maximum in Appendix A for all such applications. In addition, payments up to the maximum in Appendix A(IV) may be issued as a deposit for college room and board.

Section 359.76 Payments for Travel Expenses

a) Travel to New/Prospective Placement

Type Service Code		Document
1412	Transportation to Prospective Placement	CFS 932 or C13-1

Instructions: The Department will assume the cost of transporting a child for the purpose of placement. This travel should be by the most economical and reasonable mode available. Payments for or to non-DCFS staff who might accompany the child are to be paid from contractual funds submitted on a **C13-1, Payment Authorization**, with appropriate documentation. Worker's expenses are paid by **C-10, Travel Voucher,** accompanied by receipts and appropriate approvals. Travel expenses for wards and non-state employees will follow the same DCFS staff guidelines found in AP #12, Travel Procedures, at DCMS reimbursement rates.

b) Travel to Visit Former Placement

Type Service Code		Document
1409	Visits to Former Placements	CFS 932 or C13-1

Instructions: For children in DCFS supervised foster care placements, the Department will assume the cost of transporting a child to the home of former foster parents or relatives only when the permanency goal is to return the child to such relatives or foster parents or if past relationships are to be maintained as identified in the Service Plan. This travel should be by the most economical and reasonable mode available. Payments for or to non-DCFS staff who might accompany the child are to be paid from contractual funds submitted on a **C13-1, Payment Authorization**, with appropriate documentation. Worker's expenses are paid by **C-10, Travel Voucher,** accompanied by receipts and appropriate approvals Travel expenses for wards and non-state employees will follow the same DCFS staff guidelines found in AP #12, Travel Procedures, at CMS reimbursement rates.

c) Return of Runaway Travel - Ward

Type Service Code		Document
1410	Return of Runaway for Wards	CFS 932 or C13-1

Instructions: The Department will pay expenses related to the return of a child for whom DCFS is legally responsible. This travel should be by the most economical and reasonable mode available. Payments for or to non-DCFS staff who might accompany the child are to be paid from contractual funds submitted on a **C13-1, Payment Authorization**, with appropriate documentation. Worker's expenses are paid by **C-10, Travel Voucher,** accompanied by receipts and appropriate approvals Travel expenses for wards and non-state

employees will follow the same DCFS staff guidelines found in AP #12, Travel Procedures, at CMS reimbursement rates.

d) Non-Ward Runaway Travel, Interstate

Type Service Code		Document
1411	Return of Runaway for Non-Wards	CFS 932 or C13-1

Instructions: Travel requests must be routed through the Regional Business Office or Regional Administrator, prior to submission to the Coordinator for the Return of Interstate Runaways. This travel should be by the most economical and reasonable mode available. Payments for or to non-DCFS staff who might accompany the child are to be paid from contractual funds submitted on a **C13-1, Payment Authorization**, with appropriate documentation. Worker's expenses are paid by **C-10, Travel Voucher,** accompanied by receipts and appropriate approvals. Travel expenses for wards and non-state employees will follow the same DCFS staff guidelines found in AP #12, Travel Procedures, at CMS reimbursement rates.

e) Travel for Parental Visitation

Type Service Code		Document
1407	Parental Visits – Child Travel Expense only, eff. 11/1/07	CFS 932 or C13-1
1414	Parental Visits – Parent Travel Expense, eff. 11/1/07	CFS 932 or C13-1

Instructions: For children in DCFS supervised foster care placements, payment may be made for parental visits, either to transport the parent to the child, by using type service 1414, or the child to the parent, by using type service 1407, if all other resources (relatives, friends of the family, and unpaid volunteers) have been exhausted when the plan for the child is to return home. If the parent(s) and child(ren) will be unable to visit because no transportation is provided, or if the cost of transportation would cause the family undue hardship, transportation can be provided with the direct written consent of the Regional Administrator via the **CFS 902 - Exceptional Payment Request**, which shall be kept on file in the Regional Office. This travel should be by the most economical and reasonable mode available. Payments for or to non-DCFS staff who might accompany the child are to be paid from contractual funds submitted on a **C13-1, Payment Authorization**, with appropriate documentation. Worker's expenses are paid by **C-10, Travel Voucher,** accompanied by receipts and appropriate approvals. Travel expenses for wards and non-state employees will follow the same DCFS staff guidelines found in AP #12, Travel Procedures, at CMS reimbursement rates.

f) Travel to Attend Administrative Case Reviews

Type Service Code		Document
1413	Transportation Case Review	CFS 932 or C13-1

Instructions: For children in DCFS supervised foster care placements, **p**ayment may be made for parents and/or children to attend an Administrative Case Review if all other resources (relatives, friends, and unpaid volunteers) have been exhausted. If the parent(s) and/or child(ren) will be unable to attend the review because no transportation is provided or if the cost of transportation would cause the family undue hardship, transportation can be provided with the direct written consent of the Regional Administrator via the **CFS 902 – Exceptional Payment Request**. This travel should be by the most economical and reasonable mode available. Payments for or to non-DCFS staff who might accompany the child are to be paid from contractual funds submitted on a **C13-1, Payment Authorization**, with appropriate documentation. Worker's expenses are paid by **C-10, Travel Voucher,** accompanied by receipts and appropriate approvals. Travel expenses for wards and non-state employees will follow the same DCFS staff guidelines found in AP #12, Travel Procedures, at CMS reimbursement rates.

g) Travel for Pre-placement Visits to Prospective Adoptive Parents

Type Service Code		Document
1408	Prospective Adoptive Parents	CFS 932 or C13-1

Instructions: The Department will assume the cost of transporting a child for the purpose of prospective adoption. This travel should be by the most economical and reasonable mode available. Payments for or to non-DCFS staff who might accompany the child are to be paid from contractual funds submitted on a **C13-1, Payment Authorization**, with appropriate documentation. Worker's expenses are paid by **C-10, Travel Voucher,** accompanied by receipts and appropriate approvals. Travel expenses for wards and non-state employees will follow the same DCFS staff guidelines found in AP #12, Travel Procedures, at DCMS reimbursement rates.

Section 359.77 Payments for Certificates

a) Birth Certificates

Type Service Code		Document
1902	Birth Certificates	CFS 932

Instructions: Payment may be made to obtain copies of birth certificates when required. Refer to Procedures 302, Services Delivered by the Department, Section 302.390(a)(3), Verification of Birth. A request for the birth certificate shall be sent directly to the agency from which a certificate is being requested.

Workers who incur out-of-pocket expenses shall submit a **CFS 932, Purchase Authorization,** with a receipt and an explanation that the voucher was not accepted. The amount is as required.

b) Death Certificates

Type Service Code		Document
1903	Death Certificates	CFS 932 CFS 402

Instructions: Payment may be made to obtain copies of death certificates when required. A request for the death certificate shall be sent directly to the Illinois Department of Public Health, Division on Vital Records, on form **CFS 402, Request for Vital Record Verification**. A warrant from the Comptroller's Office shall accompany the request.

Workers who incur out-of-pocket expenses shall submit a **CFS 932** with a receipt and an explanation that the voucher was not accepted. The amount is as required.

Section 359.80 Payments for Unmarried Parents

a) Department Wards

Department wards who are unmarried parents are eligible for the same services as described in Section 359.40 through 359.70 and in Section 359.90, Payments for Medical Care.

b) Financial Aid for Ward Parents Whose Children are Living in Their Care

Ward parents may be eligible for financial and medical assistance for their child(ren) when the child is or will be living with the ward parent. When a caseworker learns that a baby has been born to a ward (and the baby will be living with the ward) the caseworker shall contact the **Federal Financial Participation, Technical Support Unit (217) 524-1974** to initiate a medical card and other financial assistance. For instructions see Procedures 302 Appendix J, Pregnant and/or Parenting Program and Procedures 359.40 (j), Special Service Fees. For payment amounts see Appendix A of this Procedure.

c) Non-Wards

The only service for which DCFS will make payment for non-ward unmarried mothers is Maternity Home Care. Refer to the Pregnant and/or Parenting Program in Appendix J of Procedures 302, Services Delivered by the Department.

Type Service Code		Document
0901	Maternity Home Care	CFS 906-1

Instructions: Payments can be made for mothers up to but not including age 18. The Regional Unmarried Parents Coordinator is responsible for all approvals. Refer to Case Opening Instructions of Procedures 304, Access to and Eligibility for Child Welfare Services.

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MEDICAL CARE

Section 359.90 Payments for Medical Care

a) Introduction to Illinois Medical Assistance Program

The Illinois Medical Assistance Program is the federal-state public assistance program which implements Title XIX of the Social Security Act (Medicaid). It is administered by the Department of Public Aid (DPA) under the Illinois Public Aid Code. The Department of Public Aid has statutory responsibility for the formulation of policy in conformance with federal and state requirements.

The objective of the Medical Assistance Program is to enable eligible persons to obtain essential medical care and services necessary to preserve health, prevent or alleviate sickness, and correct handicapping conditions. Essential care and services are those which are generally recognized as standard medical services required because of disability, disease, infirmity or impairment.

A variety of medical services are available to children for whom the Department of Children and Family Services has legal responsibility (wards). Most of these services can be obtained through DPA's Medical Assistance Program via the Medicaid card for DCFS wards with the exception of children in the home of parent (HMP), those in the Refugee Assistance Program and Armed Services Duty (ASD). Additionally, coverage has been extended to youth who have been adopted with an ongoing monthly adoption subsidy payment. (Refer to P351, Appendix A)

When any of these DCFS wards (hereafter referred to as DCFS category 98 youth) are determined Medicaid ineligible they can still receive the same medical services as eligible youth. However, payment for such services will be paid from DCFS funds in accordance with Title XIX Medicaid established rates through the Department of Public Aid.

The cost of Medicaid ineligible services for a DCFS category 98 youth is covered when the:

1) service provider is an out-of-state non-Medicaid enrolled provider or an Illinois non-Medicaid enrolled dental or optical provider and the child needs the service, and

2) provider is licensed/certified according to applicable laws of the state in which he/she practices, or

3) child is Medicaid ineligible, and

4) service has been authorized/prior approved by DCFS, and

5) service provider's bill is submitted to DPA on the appropriate form(s) within six (6) months of service delivery.

b) Other Agency Resources

State agencies other than DPA and DCFS have responsibility for coordinating the provision of selected medical services under specific conditions. When a DCFS ward is eligible for the services of other agencies, such resources must be used first. Such agencies include but are not limited to those whose programs are described below.

1) University of Illinois Division of Services for Crippled Children:

Refer to P 302, Subpart C, Appendix C, for services and referral procedures.

2) Illinois Department of Rehabilitation Services:

The Department of Rehabilitation Services has responsibility for providing services to individuals with physical or mental disabling conditions which constitute a substantial handicap to employment. Persons who are in need of medical services or prosthetic devices to improve their employability are to be referred through the local DPA or DCFS office to the Department of Rehabilitation Services.

c) Third Party Liability

The state must be assured that all other resources for payment of medical services are utilized before accepting financial responsibility for payment of medical bills. The Department of Children and Family Services will not make payment to a provider for any service for which any other third party is legally obligated to make payment. A third party is defined as an individual, institution, corporation, or public or private agency that is liable to pay all or part of the medical cost of injury, disease, or disability of a person receiving medical assistance. The Department of Children and Family Services is the payer of last resort.

It is the responsibility of the provider to ascertain from each individual whether there are other resources that are available for payment for the services rendered.

// At intake or case opening, DCFS staff must obtain and record any information regarding medical insurance or other third party who is financially liable for the child's medical expenses.

// **d) Medical Services and Information for Medicaid Eligible Services/Providers**

1) Physician Services: Covered services include these reasonably necessary and remedial services which are recognized as standard medical care required because of illness, disability, infirmity or impairment, and which are necessary for immediate health and well-being.

Qualified providers include Medicaid enrolled or licensed/certified doctors of medicine (M.D.) or osteopathy (D.O.), specialized surgeons, anesthesiologists, radiologists and M.D.s who are registered psychiatrists.

See Section e, 2C for excluded services.
Prior approval form: DPA 1409
See Section f, 2 for items requiring prior approval.
Provider billing form: DPA 2360

2) Chiropractic Services: The only chiropractic service for which payment may be made is manual manipulation of the spine to correct a subluxation of the spine which has resulted in a neuromusculoskeletal condition for which such manipulation is an appropriate treatment.

See Section e, 1 and e, 2, e for excluded services.
Prior approval form: DPA 1409
See Section f, 2 for services requiring prior approval.
Provider billing form: DPA 1443

3) Dental Services: Payment is made for those services essential to prevent dental disease and to restore and maintain adequate dental function to assure good bodily health of the patient.

See Section e, 1 and e, 2, d for excluded services.
Prior approval form: DPA 2242
See Section f, 2 for services requiring prior approval.
Provider billing form: DPA 134

4) Audiological Services: Audiological services are those services consisting of basic and advanced hearing tests, hearing aid evaluations, counseling, hearing aid fitting and retesting of amplification upon the completion of the 30 day trial with a hearing aid and those services offered by a hearing aid dispenser, including the dispensing, fitting, repair, replacement of parts, and the provision of hearing aid accessories.

See Section e 1 for excluded services.
Prior approval form: DPA 2240
See Section f 2 for services requiring prior approval.
Provider billing form: DPA 1443

5) Podiatry Services: Services covered are limited and include only diagnostic, laboratory and surgical services for which medical necessity is clearly established.

See Section e, 1 and e, 2, g for excluded services.
Prior approval form: DPA 1409
See Section f, 2 for services requiring approval.
Provider billing form: DPA 1443

6) Optician and Optometrist Services: Covered services include the provision of glasses and other materials which are required to restore and conserve vision. Only one pair of glasses will be provided in a 12 month period. (Replacement glasses within a twelve (12) month period may be authorized for a DCFS category 98 child through the DCFS prior approval process.)

See Section e, 1 and e, 2, H for excluded services.
Prior approval form: DPA 1409
See Section f, 2 for prior approval process.
Provider billing form: DPA 1443

7) Therapy Services: Providers include physical therapists, occupational therapists, and speech therapists/pathologists.

See Section e, 1 and e, 2, I for excluded services.
Prior approval form: DPA 1409
See Section f, 2 for services requiring prior approval.
Provider billing form: DPA 1443

8) Independent Laboratory Services: Payment for services will be made only when the following conditions are met: a) the test for which charges are made is within the specialties or subspecialties the laboratory is certified by Medicare to provide and b) the individual's referring practitioner has provided the laboratory with a written signed order which includes the diagnosis or condition.

See Section e, 1 and e, 2, B for excluded services.
There is no prior approval form for services.
Provider billing form: DPA 2211

9) Medical Equipment/Supplies: A written recommendation of patient care plan authorized by the individual's physician is required in the provision of medical supplies and equipment. Medical items/ services covered are: a) non-durable medical supplies, b) durable medical equipment, c) prosthesis and orthoses, d) respiratory equipment/supplies and e) repair, alteration, and maintenance of necessary durable medical equipment, prothesis and orthoses.

See Section e, 1 and e, 2, a for excluded services/items.
Prior approval form: DPA 2240
See Section f, 2 for services/items requiring prior approval.
Provider billing form: DPA 2210

10) Medical Transportation Services: Transportation to or from a source of medical care is a covered service if the transportation is not available without charge. Oxygen usage is a covered service when required during transport by ambulance. Use of an attendant during transport by Medicar is a covered service when medically indicated. Eligible providers include:

A) Ambulances inspected by Department of Public Health (DPH)

B) Medicars certified by the Illinois Commerce Commission (ICC)

C) Taxicabs certified by the Secretary of State and where appropriate, by local regulatory agencies.

D) Service cars (vehicles in business for hire)

E) Private auto

F) Other modes of transportation (bus, train, airplane, etc.). Providers must be enrolled and approved by DPA for participation in the Medical Assistance Program. Foster parents can become transportation providers when necessary to ensure adequate medical care for the child.

Prior approval for medical transportation of a DCFS category 98 child will be authorized by DCFS Regional staff.

See Section e, 1 and e, 2, F for excluded services.
Prior approval form: DPA 2239
See Section f, 2 for services requiring prior approval.
Provider billing form: DPA 2209

11) Pharmacies - Drugs/Prescriptions: Included are drugs in DPA's Handbook for Pharmacies or drugs/medications not in the Handbook for which the prescribing physician or pharmacist has obtained prior approval via DPA's Pharmacy and Drug Prior Approval Unit. (When any other required drugs/medications are needed for a DCFS category 98 child, authorization will be in accordance with Section F, 3, of these procedures.)

See Section e, 1 and e, 2, J for excluded services.
No prior approval form required.
See Section f, 2 for prior approval process.
Provider billing form: DPA 215

12) Inpatient Hospital: Providers include general hospitals, psychiatric hospitals, and physical rehabilitation hospitals. General inpatient hospital services include medical, surgical, pediatric orthopedic, maternity and intensive care services. Inpatient psychiatric services may be provided by a general hospital or by a psychiatric hospital enrolled with DPA for this category of service. Inpatient psychiatric services provided by psychiatric hospitals are covered services for recipients under age 21. Regardless of where inpatient psychiatric services are provided, Medicaid coverage is limited to a maximum of twenty (20) days per admission and forty-five (45) days in any calendar year. When a short-term extension (up to 5 days) is required subsequent to either a twenty (20) or forty-five (45) day stay, the attending physician must request the extension directly from DPA.

See Section e, l for excluded services.
Provider billing form: DPA ll7

13) Physical Rehabilitation Services: Provided by a general hospital or a rehabilitation hospital enrolled with DPA for this category of service. The recipient must have a major physical disability which may be substantially altered by a program of intensive physical rehabilitation.

See Section e, 1 for excluded services.
See Section f, 2 for services requiring prior approval.
Provider billing form: DPA 117

14) Outpatient Hospital: General outpatient hospital services include referred services (physician referral) for lab tests, X-rays, etc., and emergency services.

See Section e, 1 for excluded services.
No prior approval form required.
Provider billing form: DPA 1438

15) Clinic Services: Included are general clinic services, psychiatric clinic services and physical rehabilitation clinic services. General clinic services are diagnostic, therapeutic and palliative services provided under the direction of a physician. Psychiatric clinic services Type A include diagnostic evaluation, individual therapy, control of medication, electric shock treatment, counseling, group therapy and family therapy. Psychiatric clinic services Type B is an active treatment program in which the individual recipient is participating in social, recreational and task-oriented activities. This treatment program is limited to six months in any twelve (12) month period. Physical rehabilitation clinic services should be utilized when the recipient's condition does not necessitate inpatient care.

See Section e, 1 for excluded services.
No prior approval required.
Provider billing form: DPA 1438

16) Psychological Tests: Must be administered by a registered practicing psychologist. It is a DPA-covered service when the tests are for the purpose of determining the child's functioning related to the continuing suitability of a current living arrangement, or need to secure a new living arrangement or other permanency related placement. The provider must list the tests completed and report the time involved for each test.

See Section e, 1 for excluded services.
No prior approval form required.
Provider billing form: DPA 2734
See Section f, 4 for other psychological services.

17) Nursing Services: Covered services include those services provided by registered nurses and nursing services provided through home health agencies by physician referral.

Prior approval form: DPA 1409
Provider billing form: DPA 1443

18) Psychiatric Services: These services can only be provided by qualified providers who are licensed by the state to provide psychiatric services.

See physicians, inpatient hospital, outpatient hospital and clinic services listed in this section.

Prior approval form: DPA l409
Provider billing form: DPA 2360

19) Other Medical Services: For information on any medical service not explained in this section, refer to Sections E and F of these procedures or contact the appropriate DCFS Regional Medical Liaison.

20) Healthy Kids Program (formerly Medichek)

A) Purpose

The Healthy Kids Program is intended to offer Early Periodic Screening, Diagnosis and Treatment Services (EPSDT) to children on welfare and to ensure diagnosis and treatment of suspected problems discovered through such examinations. EPSDT is expected to evaluate children by means of clinical observations and specific screening procedures to separate the "well child" from the child who appears to need a more definitive evaluation. This EPSDT process allows all Healthy Kids Program eligible children access to a continuing health care program on a periodic basis. Included in this health care program are all required immunizations. When a well child enters the first substitute care placement he/she is to be given a Healthy Kids Program examination regardless of age. The Healthy Kids Program provider must note "Healthy Kids Program service per DCFS request" on the billing form. (Refer to P302(67) for the Healthy Kids Program age schedule.)

B) How to Secure Healthy Kids Program Services for a DCFS Ward

There are two methods available to secure services:

The first method is as follows:

When a Medicaid case is opened on DPA's system for a DCFS category 98 child, DPA will send the foster parents/caregiver of the child a Form DPA 2280 which is a postcard that requests the foster parents/caregiver to fill out the card if help is needed in 1) making an appointment for a Healthy Kids Program exam, 2) making an appointment for a dental exam, or 3) transportation to and from a Healthy Kids Program or dental exam. Failure to return this card does not affect Title XIX medical benefits or any financial aid that is being received. Healthy Kids Program services may still be requested any time.

If the foster parent completes the card and mails it back to DPA, a form DPA 2285 (Healthy Kids Program Outreach Request Follow-Through) will be sent to the assigned DCFS caseworker to help the foster parent/caregiver set up an

appointment or arrange for transportation. After the child receives his/her initial Healthy Kids Program screening, he/she is enrolled in the Healthy Kids Program.

The second method is as follows:

The foster parent/caregiver or responsible party can make an appointment with a Healthy Kids Program enrolled provider for a screening. After the child receives his/her initial screening, he/she is enrolled in the Healthy Kids Program.

C) Services Offered by Healthy Kids Program

i. Required School Health Examinations:

Healthy Kids Program screenings (health exams) are available for entry into Head Start and kindergarten, or grades 1, 5, and 9. A Healthy Kids Program screening is to be requested and the provider must make the notation that it is a school health exam.

ii. Immunizations:

All required immunizations.

iii. Day Care Pre-Admission Physical Exam:

A Healthy Kids Program screening can be used for this purpose for a DCFS category 98 child.

iv. Camp Physical:

The Healthy Kids Program will pay for a physical examination for a DCFS category 98 child who is authorized to attend a camp and a physical examination is required for admittance to camp.

v. Employment Physical:

The Healthy Kids Program will pay for an employment physical for a DCFS category 98 child.

vi. School Sports Physical:

The Healthy Kids Program will pay for a school sports physical for a DCFS category 98 child.

vii. Foster Care Placement Physical Exam:

The Healthy Kids Program will pay for a physical exam for a DCFS category 98 child entering foster care placement.

D) Provider Billing Form

The provider who performs the Healthy Kids Program screening completes form PH0600. When the service is for a DCFS category 98 child, the provider must enter "per DCFS request" on the PH0600. The PH0600 is a dual purpose 4-page form; the first two copies are the billing form for the provider to be paid for his services. The provider keeps the second copy for his records and mails the remaining 3 copies to DPA. DPA will enter the information into its payment system and after payment is authorized, the last two copies will be forwarded to the assigned DCFS caseworker for a follow-up on the client, if a referral for other medical services was made by the Healthy Kids Program provider. It is the responsibility of the DCFS case-worker to ensure that the client is aware of the referral and to be aware of the course of action the client intends to take regarding the referral.

21) Funeral and Burial Expenses

The following payment procedures for funeral and burial expenses apply for all medicaid eligible children for whom the Department is legally responsible, their newborn children who may not have been added to their case, as well as medicaid eligible children under the Subsidized Guardianship and Adoption Assistance programs. The Illinois Department of Human Services (IDHS) pays up to a maximum rate for funeral and burial expenses. Eligibility is based on medicaid requirements and questions should be directed to the nearest IDHS office.

A) Direct Vendor Payment:

The vendor (funeral home or cemetery) shall be presented with the medical card of the deceased child. The vendor shall then prepare the IDHS form, IL. 444-0029, Funeral or Burial Claim, attach the necessary receipts, and submit the required paperwork to IDHS, at the address listed below for payment. Upon receipt, IDHS reviews the submitted claim and, after approval of the request, pays for the approved burial and funeral expenses directly to the submitting vendor.

IDHS form, IL. 444-0029, Funeral and Burial Claim, must be filled out and submitted along with copies of the receipts to: Illinois Department of Human Services, Funeral and Burial Unit, 305 E. Monroe, Springfield, IL. 62701.

B) Reimbursement:

Persons not legally responsible for the deceased may file a claim when they voluntarily assume responsibility for the funeral and burial expenses, and pay an amount equal to or more than the amount of the claim. IDHS pays only one reimbursement claim per case. When two or more people are paying, only one can file a claim for reimbursement.

C) Reimbursement Claims:

All initial claims must be submitted to the address listed above, within 30 calendar days after the date of death. Claims submitted after 30, but up to 180, calendar days should include a written statement by the claimant explaining the cause for the delay. Initial claims not submitted within 180 days will be denied regardless of the reason.

IDHS form, IL. 444-0094, Funeral and Burial Reimbursement claim, must be filled out and submitted along with copies of the receipts to the address listed in section (a). IDHS Form IL. 444-0094 may be obtained directly from the funeral home or from the nearest IDHS office.

Note: For reporting procedures due to the death of a ward, refer to Procedures 331, Unusual Incidents.

22) Abortions

The Illinois Department of Public Aid will not pay for abortions performed under any of the medical programs it administers, except when an Illinois licensed doctor has determined, in his/her professional judgment, that the life of the mother would be endangered if the fetus were carried to term. Doctors and hospitals will not be able to accept medical eligibility cards for abortions except as specified above.

e) Medicaid Ineligible Services

1) General Services Not Covered by Medicaid

Services and supplies for which payment cannot be paid as Medicaid eligible include, but are not limited to, the following (see Section e, 2 below for other exclusions which are related to specific categories of service):

A) Services available without charge.
B) Services prohibited by state or federal law.
C) Experimental procedures.
D) Research oriented procedures.
E) Medical examinations required for entrance into educational or vocational programs.
F) Autopsy examinations.
G) Preventive services, except those provided through the Healthy Kids Program for children through age 20, and required school examinations.
H) Routine examinations.
I) Artificial insemination.
J) Abortion, except in accordance with DPA Rule 4.03 (see Section d, 22).
K) Medical or surgical procedures performed for cosmetic purposes.
L) Medical or surgical transsexual treatment services.

M) Diagnostic and/or therapeutic procedures related to primary infertility/sterility.
N) Acupuncture.
O) Subsequent treatment for venereal disease, when such services are available through state and/or local health agencies.
P) Medical care provided by mail or telephone.
Q) Unkept appointments.
R) Medically unnecessary items and services provided for the convenience of individuals and/or their families.
S) Preparation of routine records, forms and reports.
T) Visits with persons other than a recipient, such as family members or group care facility staff.
U) Desi ineffective drugs.

2) Specific Services Not Covered by Medicaid

A) Medical Equipment/Supplies

i. Items/services for which medical necessity is not clearly established.
ii. Items/services inappropriate for the individual's medical condition.
iii. Prostheses inserted or implanted which do not increase physical capacity, overcome a handicap, restore a physiological function, or eliminate a functional disability.
iv. Items/services where DPA prior approval has not been obtained when required.
v. Stock orthopedic shoes made on special order and attached to a brace.
vi. Medical equipment and supplies for persons who are residents of long-term care facilities, except when the item is necessary for the continuous care and exclusive use of the individual to meet an unusual medical need.
vii. Major bracing and prosthesis except when recommended by a licensed/certified amputee clinic or rehabilitation center.

B) Laboratory Services

i. Laboratory services when not specifically required by the condition for which the recipient is being treated.
ii. Laboratory services provided to persons eligible for Medicare Part B benefits when the Medicare intermediary determines that the services are not medically necessary.
iii. Laboratory tests which are available without charge from the Illinois Department of Public Health or other private and governmental agencies (e.g. cities and counties).
iv. Tests and study of specimens referred as a result of an autopsy examination.

v. Tests which have not been performed on the laboratory's premises, by the laboratory's staff, using the laboratory's equipment and supplies.
vi. The collection and handling of specimens obtained for referral to another laboratory.
vii. Sensitivity studies when a culture shows no growth or when a growth is identified as beta hemolytic streptococcus.
viii. Tests ordered for Healthy Kids Program screening purposes.

C) Physicians

i. Examinations required for the determination of disability or incapacity.
ii. Services provided in federal or state institutions.
iii. Procedures performed to attempt to restore fertility subsequent to sterilization.
iv. Those prostheses inserted or implanted which do not increase capacity, overcome a handicap, restore a physiological function or eliminate a functional disability.

D) Dental Services

i. General screening when there is no presenting complaint and request for care.
ii. Routine or periodic examinations other than:
    - o Initial examination
    - o Periodic examinations, when a minimum of 12 months has elapsed since the initial or previous periodic examination
    - o Required school examination
iii. Acrylic crowns
iv. Provider transportation costs to provide services at a location other than the dentist's office.
v. Full mouth X-rays taken more than once every 3 years.
vi. Root canal treatment and apicoectomies for other than front teeth.
vii. Complete dentures except for AABD recipients and only for adult AFDC recipients.

E) Chiropractic Services

i. Diagnostic office visits (screening).
ii. X-rays and laboratory tests provided in office.

F) Medical Transportation

i. Non-emergency transportation where prior approval has not been given.

ii. Services inappropriate for the individual's condition (e.g., a non-emergency ambulance trip when a service car trip is warranted).
iii. Services of a paramedic, emergency medical technician, or nurse.
iv. Transportation of a person having no medical need.
v. "No Show" trips.
vi. Charges for mileage other than loaded miles--miles incurred while actually transporting the patient.
vii. Transportation of a deceased child.
viii. Charges for waiting time.
ix. Charges for meals, lodging, parking, tolls.
x. Transportation by a non-adoptive legally responsible relative.
xi. Transportation provided by vehicle other than those owned or leased and operated by the provider.

G) Podiatry Services

i. Visits and services provided to individuals eligible for Medicare benefits, if the services are determined not medically necessary by Medicare.
ii. Preventive or reconstructive services.
iii. Screening for foot problems.
iv. Visits by more than one family member on the same day when definitive pathology is not present.
v. Provider transportation cost.
vi. X-rays, laboratory work or similar services when not specifically required by the primary condition for which the recipient is being treated.
vii. X-rays and laboratory procedures performed at a location other than the podiatrist's own office.
viii. Routine post-operative visits.
ix. Surgical assistants and/or co-surgeons.
x. Services available from other sources including, but not limited to, private and governmental agencies.
xi. Treatment of flat feet, non-involved sprains or strains and minor skin condition, including services directed toward the care or correction of these conditions.
xii. Any services billed in association with non-covered services, such as X-ray, laboratory, routine visits.
xiii. Services performed in the absence of localized illness, symptoms or injury involving the foot or digit.
xiv. Repeat surgery performed because original surgery was not successful.
xv. Podiatric consultations.

H) Optician/Optometrist Services

i. Non-standard frames which are not considered as standard.
ii. Frames replaced due to the recipient's preference for a change in style, color, etc.
iii. Second pair of eyeglasses within one year unless lost or broken.

I) Therapy Services (Physical, Occupational, Speech)

Services offered at no charge by private or governmental agencies (e.g., speech therapy/correction classes offered by school districts).

J) Pharmacy Items

Those items/drugs which are not listed in the DPA Handbook for which no prior approval has been obtained.

// **f) Prior Approval Process**

1) DPA

Prior approval by DPA is required for certain Medicaid eligible services/items in order for payment to be made. The prior approval is an authorization for the provider to bill for these services. Services/items requiring prior approval are identified in Sections D and F and in the DCFS Prior Approval Handbook. The appropriate forms to be used for requesting prior approval are explained in Section d of these procedures and the Handbook.

Providers are responsible for obtaining DPA prior approval for Medicaid eligible services/items. Approval is not transferable; only the provider who submitted the request may provide the approved services/items.

In cases of emergency the provider can request oral prior approval by telephoning the appropriate DPA Prior Approval Unit. If the child's condition is so severe that his or her life is endangered and there is not enough time to seek approval by telephone, or the service is needed at a time when DPA's office is closed, the service may be provided before obtaining prior approval. When an emergency approval is obtained by telephone or the service is provided before obtaining prior approval, the provider must still submit the request in order to receive an approval authorization for billing purposes.

The provider and the child's caretaker will receive notification of the action taken on a prior approval request. When the request is denied, the child's caretaker will be advised of his/her right to appeal the decision and to have a fair hearing. The provider may not appeal, but is to be advised that the request for an appeal will be referred to DCFS for consideration.

2) Services Requiring DPA Prior Approval: Abortion, sterilization, hysterectomy and surgery for morbid obesity require prior approval. Additionally the following services require prior approval:

A) Chiropractic Services

i. Continuous treatment for the same diagnosis involving more than six visits.
ii. Continuous treatment for the same diagnosis exceeding a period of 21 days.

B) Dental Services

i. Space management therapy
ii. Crowns
iii. Root canal therapy - front teeth only
iv. Periapical services
v. Periodontal treatment
vi. Dentures - partial and complete
vii. Fixed prosthodontics (bridge pontics and crowns)
viii. Surgical extraction of impacted teeth
ix. Alveoloplasty
x. Removal of cysts and neoplasms
xi. Frenulectomy
xii. Comprehensive orthodontic treatment
xiii. Analgesia (anesthesia)

C) Audiological Services

i. Hearing aids
ii. Hearing aid repair when cost will exceed $100.00.

D) Podiatry Services

i. Orthomechanics
ii. Multiple surgery (or procedures) for bilateral bunion corrections with osteotomies of the first metatarsals.
iii. Surgical procedures within six-month period following original surgery.
iv. Services and/or procedures not specifically identified in DPA Handbook for Podiatrists.

E) Therapy Services (Physical, Occupational, Speech)

All therapy services except those therapy services provided in the 30 calendar day period immediately following hospital discharge if the patient was already receiving therapy while hospitalized.

F) Medical Transportation Services

Prior approval is required by DCFS prior to the provision of transportation services to and from the source of medical care, except for emergency ambulance service.

G) Medical Equipment/Supplies

Prior approval is required for the provision of <u>all</u> medical equipment/supplies.

H) Pharmacies

Any item that is not listed in the DPA Handbook for Pharmacies which a physician deems essential for treatment of the ward. Prior approval for drugs not listed in the DPA Pharmacy Handbook may be obtained for a DCFS category 98 child when the required drug is by prescription from a physician. The pharmacist or physician must call the DPA Pharmacy and Drug Prior Approval Unit at 1-800-252-8942 during regular business hours.

I) Optician/Optometrist Services

i. Soft/hard contact lens
ii. Contact lens service
iii. Gas permeable
iv. Custom-made artificial eye(s)
v. Low vision device

J) Physical Rehabilitation Services

i. Prior approval is <u>not</u> required for outpatient physical rehabilitation.
ii. DPA prior approval is not required for the first 30 days of inpatient physical rehabilitation, but if more than 30 days of inpatient services are required, prior approval is needed.

3) <u>DCFS</u>

Prior approval by DCFS' Regional Medical Liaison is required for certain services/supplies which are ineligible under the Medicaid program, but are required for DCFS category 98 children. The provider must submit the prior approval request on the appropriate DPA prior approval request form. When prior approval is granted, it is not transferable to another service provider.

Prior approval for Medicaid eligible transportation for DCFS category 98 youth will be authorized by DCFS Regional Staff.

The DCFS prior approval process is designed to ensure:

A) access to Medicaid ineligible services for DCFS category 98 youth,

B) reimbursement to Medicaid enrolled or registered providers through DPA's payment system, and

C) reimbursement at a rate in accordance with Title XIX guidelines or DCFS approved rates.

Service providers requesting DCFS prior approval must follow these specific guidelines:

A) Be Medicaid enrolled or licensed/certified according to applicable state laws.

B) Ensure that the needed service is not a Medicaid eligible service in accordance with the DPA Provider Handbook.

C) Complete the appropriate DPA prior approval request form.

D) Submit the prior approval request form to the DCFS Regional office in the area where the child is served.

The DCFS Regional Medical Liaison shall review the prior approval request form for accuracy and completeness. The decision to approve or deny the requested service shall be determined by individual case circumstances, caseworker consultation as appropriate, the need for the service and shall not conflict with the child's service plan. Decisions to approve or deny the prior approval request shall be made as soon as possible, but no later than five (5) working days after receipt.

Approved Requests

Payment to the service provider is not guaranteed unless the prior approval request is approved by the DCFS Regional Medical Liaison. The DCFS approval authorizes the provider to bill DPA and payment will be made in accordance with the Medicaid or DCFS authorized rates.

When prior approval is granted, the DCFS Regional Medical Liaison staff shall assign an authorization number (from the designated set of numbers) on the prior approval form and complete the appropriate data boxes. All approved requests shall be separated by service type; i.e., dental, optometry, podiatry, etc., before being batched and forwarded to DPA on a daily basis. The prior approvals shall be mailed in an envelope which has been clearly marked/stamped in red ink "DCFS Prior Approvals" to Department of Public Aid, P.O. Box 4071, Springfield, IL 62708.

After receipt, DPA will data enter the authorized prior approvals into their system and subsequently notify the provider that prior approval has been granted.

Denied Requests

When a prior approval request is denied by DCFS, the DCFS Regional Medical Liaison shall notify the service provider, the ward and foster parent/caretaker by letter, stating the reason for denial. The ward and foster parent/caretaker shall be advised of their right to appeal the decision in accordance with Part 309, Review and Appeal Process.

Emergency Prior Approvals

A medical provider may obtain authorization for an emergency DCFS prior approval for a Medicaid ineligible service via telephone to the appropriate DCFS Regional Medical Liaison. An "emergency" is defined as a medical condition or situation which threatens the life of the child; may cause permanent damage to the child; requires services to relieve immediate or significant pain and suffering; or is a service or item necessary for the timely release of the child from acute hospital care.

If the child's condition is so severe that his/her life is threatened and there is not sufficient time to request DCFS prior approval by telephone or the emergency occurs during non-working hours, the service may be provided without prior approval. The service provider must submit the appropriate prior approval request form to the DCFS Regional office on the next working day when an emergency prior approval was granted via telephone or when emergency service was provided (as described above) and prior approval was not secured. The service provider must document that the service was provided as an emergency. Emergency prior approvals shall be completed/processed as noted under Approved Requests.

4) Medicaid Ineligible Services Requiring DCFS Prior Approval

Payment for certain Medicaid ineligible services/supplies can be authorized through the DCFS prior approval process when required for the health and well-being of a category 98 child. Reimbursement to the service provider will be made by DPA following receipt of a prior approval authorization from a DCFS Regional Medical Liaison or appropriate billing forms with DCFS authorization. When services/supplies are needed but Medicaid eligibility cannot be determined, contact the DCFS Medical Liaison in your Region.

Medical services/supplies which are covered via DCFS prior approval include, but are not limited to:

General Services

A) Medical examinations required for entrance into educational or vocational programs.
B) Autopsy examinations.

C) Preventive services, except those provided through the Healthy Kids Program for children through age 20, and required school examinations.
D) Routine examinations when required for placement purposes.
E) Medical or surgical procedures performed for cosmetic purposes.
F) Preparation of routine records, forms and reports.

Specific Services

A) Medical Equipment/Supplies

i. Stock orthopedic shoes.
ii. Medical equipment and supplies for category 98 wards who are residents of long-term care facilities when the item is necessary for the continuous care and exclusive use of the ward to meet an unusual medical need and the item is not Medicaid eligible.
iii. Bracing and prosthesis when not Medicaid eligible and recommended by a licensed/certified amputee clinic or rehabilitation center.

B) Laboratory Services

i. Laboratory services when not specifically required by the condition for which the ward is being treated (e.g., court-ordered).
ii. Laboratory tests which are not available without charge from the Illinois Department of Public Health or other private and governmental agencies (e.g., urine/blood test).
iii. Tests and study of specimens referred as a result of an autopsy examination.
iv. Tests which have not been performed on the laboratory's premises, by the laboratory's staff, using the laboratory's equipment and supplies (e.g., urine/blood tests).
v. The collection and handling of specimens obtained for referral to another laboratory.

C) Physicians

Examinations required for the determination of disability or incapacity.

D) Dental Services

i. Full mouth X-rays more than once every 3 years, when required.
ii. Root canal treatment and apicoectomies for other than front teeth.
iii. Complete dentures.

E) Chiropractic Services

i. Diagnostic office visits (screening).
ii. X-rays and laboratory tests provided in office.

F) Medical Transportation

i. Services of a paramedic, emergency medical technician, or nurse in cases of extreme emergencies.
ii. Charges for mileage other than loaded miles, only under extreme circumstances.
iii. Transportation of a deceased child.
iv. Charges for meals, lodging, parking, tolls.
v. Transportation provided by vehicle other than those owned or leased and operated by the provider.
vi. Transportation cost for foster parent when the child must be accompanied to/from the source of medical care.

G) Podiatry Services

i. Preventive or reconstructive services.
ii. Screening for foot problems.
iii. Provider transportation cost.
iv. X-rays and laboratory procedures performed at a location other than the podiatrist's own office.
v. Routine post-operative visits.
vi. Treatment of flat feet, non-involved sprains or strains and minor skin condition, including services directed toward the care or correction of these conditions.
vii. Any services billed in association with non-covered services, such as X-ray, laboratory, routine visits.
viii. Repeat surgery performed because original surgery was not successful.
ix. Podiatric consultations.

H) Optician/Optometrist Services

i. Non-standard frames when determined necessary.
ii. Second pair of eyeglasses within one year as a replacement or due to changes in prescription.

I) Pharmacy Items

Those items/drugs which are not listed in the DPA Handbook for Pharmacies, and other DCFS authorized medications/drugs which are deemed necessary. This does not include desi-ineffective drugs.

J) Psychological Services

Evaluations/assessments to diagnose a particular problem related to the suitability of a current or new placement, but not ongoing therapy to treat the problem. NOTE: This service is not available to DCFS wards in the home of

parent(s). The evaluation/assessment may be court-ordered or may be needed prior to or in conjunction with psychological tests related to placement planning. The provider is limited to five (5) sessions to complete the evaluation/assessment. Requires authorization by Field Office Supervisor or Unit Supervisor unless the service(s) is court-ordered.

K) Coverage for Essential Services

i. MANG spend-down medical expenses incurred by a ward if the ward does not reach the required spend-down amount within the six month period.
ii. Payments to Illinois dental or optical providers or any out-of-state providers who provide services to DCFS category 98 wards but who are not enrolled as approved DPA providers.
iii. Inpatient psychiatric hospitalization that exceeds the length of stay limitations established by DPA and DMH/DD.
iv. Outpatient psychiatric hospital visits that exceed the limitations established by DPA and DMH/DD.
v. Psychological tests, evaluations/assessments for the ward's family member(s) and/or caretaker(s) for placement planning purposes. (Excludes wards in the home of parent.)
vi. Any other medical service or item that DPA has excluded or does not cover but is determined by a physician to be essential to the health and well-being of the child for which DCFS has provided authorization.

// **g) Payment Procedures – Medicaid Eligible Services**

1) Procedures for Processing Medical Bills

All medical bills for Medicaid eligible services which are incurred on behalf of a DCFS category 98 child through the DPA medical card (DPA 469--Regular Medical Eligibility card or DPA 469D--Temporary Medical Eligibility card) will be processed through DPA's payment system. Bills for Medicaid eligible services must be submitted on the appropriate DPA billing forms to the Department of Public Aid.

When medical services are billed to DPA, the child's Recipient Identification Number (RIN) must be entered on the DPA billing form before submittal. The child's RIN is listed on the Regular Medical Card—DPA 469. However, when services are provided through the Temporary Medical card—DPA 469D, the provider can obtain the child's RIN by telephoning the DCFS Central Office Eligibility Unit at 1-800-228-6544.

Payment procedures for Medicaid-ineligible services are covered in Section h.

2) Psychological Tests

When psychological tests are required for a DCFS category 98 child, approval shall be authorized via the Field Office Supervisor except when court ordered. The Field Office Supervisor or Unit Supervisor shall send a referral letter to the selected psychologist which explains the circumstances or need for tests. Simultaneously, a copy of the referral letter shall be forwarded to the appropriate Regional Medical Liaison.

Charges for psychological tests which are administered by a registered psychologist for the purpose of determining a DCFS category 98 child's functioning related to the continuing suitability of a current living arrangement or need to secure a new living arrangement must be submitted to DPA. The C-13 (Invoice Voucher) and the DPA 2734 (Statement of Psychological Services Rendered) will be used for billing purposes and must be completed in accordance with the following instructions:

o DPA 2734

The DPA 2734 must be completed by the service provider in accordance with instructions on the form. An individual form must be completed for each child served, but it is permissible to bill a series of charges for the same child and the same type service on one (1) form. All information related to the child and/or tests given must be typed or legibly printed. The provider's FEIN or Social Security number and an Illinois or out-of-state Registration number must be entered under item 2 and 3 respectively. Item 6 must contain the name of the child to whom the test(s) was given. The completed form must contain the provider's original signature and be forwarded to the Regional Medical Liaison in the Region with service responsibility for the category 98 ward. NOTE: Out-of-state providers must attach a copy of their state registration. After receipt by the Regional Medical Liaison, the form shall be reviewed for accuracy of information and charges.

The DPA 2734 shall not be forwarded to DPA when there are discrepancies, but when the information is correct, the Medical Liaison shall sign and date the form (items 19 and 20) and forward it with the C-13 to DPA. The Regional Medical Liaison must also enter his/her Region in item 21.

o C-13

The Regional Medical Liaison shall ensure that the correct information is entered on the C-13, Invoice Voucher. All entries must be typed:

Item 1 -- Enter name and location of state agency as
Department of Public Aid, 628 East Adams,
Springfield, Illinois 62708.

Item 2 -- Enter the provider's FEIN or Social Security number and zip code.

Item 3 -- Enter provider's name (last name first) and address (city, state, zip).

Item 10 - Enter the statement: "DCFS Authorized Services for:" child's name and child's 98 case identification number. Directly below this information, enter "Date(s) of Services". When the child has received several tests during the same month, enter only the first (1st) date of service in that month (e.g. tests were administered on March 3rd, 5th, and 6th, enter March 3, 1986). DO NOT ENTER the name/type of test nor the fee from the DPA 2734; DPA staff will complete this information. Directly below the Date(s) of Services, enter "Needs Code: 210," and below the Needs Code, enter "DO NOT RECOUP". Use needs code 210 for psychological tests administered to DCFS category 98 wards for placement purposes, and initiated by DCFS or court-ordered.

Since the C-13 will be used for provider payment, it is important to ensure accuracy on the form. When entering the provider's FEIN/Social Security number in Item 2, do not leave any spaces between numbers. In Item 10, charges for more than one child may be entered when the psychological tests were administered by the same psychologist to several DCFS category 98 wards. The number of entries should never exceed seven (7) and the Needs Codes (210 and 211) cannot be mixed on a C-13 Voucher. If a DPA 2734 shows psychological services administered under both categories (210 and 211) a separate C-13 must be used for each category of services. DCFS staff shall sign and date the C-13 as Receiving Officer in Item 26. When the C-13 has been completed, attach the DPA 2734 and any other appropriate documentation (copy of out-of-state registration) and mail to Department of Public Aid, Claims Processing Unit, 931 East Washington, Springfield, Illinois 62763, Att: Carole Luttrell.

3) Submittal of Charges to DPA

To be eligible for DPA payment consideration, a provider's claim or bill must be received by DPA no later than six (6) months from the date on which medical goods or services were provided. Exceptions to this requirement will be permitted only for the following circumstances:

A) The provider was not informed of the child's eligibility for medical assistance.

B) A third party billing was made within six (6) months following the date of service and the third party did not adjudicate such billing in sufficient time to allow for the provider's timely submittal of the remaining unpaid charges. In such cases, a claim for the remaining charges must be received by DPA no later than six months from the final adjudication by the third party.

4) Resubmittal of Rejected Claims to DPA

A claim may be resubmitted to DPA for payment consideration only when the initial claim was submitted within six (6) months of the date of service and the claim has been:

A) Reported by DPA on the Remittance Advice as being rejected for payment, and the condition that caused the rejection can be and has been corrected.

The resubmitted claim must be received by DPA no later than twelve (12) months following the date of service or, if applicable, twelve (12) months following the date of the DPA notice of decision on an application, or twelve (12) months following the date of third party final adjudication.

B) Never reported by DPA on a Remittance Advice as being paid, suspended or rejected, and the provider has made written inquiry to DPA within six (6) months of the date of service regarding the status of the specifically described, unreported claim.

A resubmitted claim must be received not later than twelve (12) months from the date of service and will be considered for payment only if there is attached to the claim a copy of the provider's timely letter of inquiry to DPA regarding the status of the previously submitted, unreported claim.

C) Rejected because of errors in completing the DPA billing form. The errors should be corrected and the billing form resubmitted to DPA for payment.

5) Pricing of Medicaid Eligible Services

A) Hospitals

Inpatient

DPA will pay for inpatient hospitalization services at the hospital's established DPA Title XIX inpatient per diem rate. This rate includes all services provided by the hospital.

Outpatient

DPA will pay the established DPA Title XIX outpatient per unit rate. The outpatient per unit rate is multiplied by the number of different units used by the patient on the one visit (e.g., lab, X-ray, EKG, emergency room). Each unit may only be counted as one unit regardless of how many times that unit is used.

Out-of-State

If the out-of-state hospital is enrolled as an Illinois DPA provider, DPA will pay the established Title XIX rates.

B) Psychological Tests

The rate of payment to a registered psychologist for psychological tests related to placement will be in accordance with established Medicaid rates for Registered Psychologists.

C) Other Services/Supplies

All other medical services/supplies which are Medicaid eligible will be paid at the Title XIX rate.

// **h) Payment Procedures – Medicaid Ineligible Services/Providers**

1) Payment Processing – Ineligible Services

Payment for certain Medicaid ineligible services/supplies provided on behalf of a DCFS category 98 child may be paid from DCFS funds through the Department of Public Aid's payment system. When medical services/supplies cannot be covered as Medicaid eligible or DCFS authorized through DPA, the cost must be paid from DCFS Regional dollars. (Refer to Section 359.9 d, e and f to determine which medical services/supplies are Medicaid eligible or which may be DCFS authorized through DPA.)

The charges for DCFS prior approval services/supplies must be submitted to DPA through the DCFS Regional Medical Liaison. The charges must be on or attached to DPA billing forms. Some charges will be submitted on a C-13, (Invoice Voucher) with a DPA billing form attached. All provider claims/bills must be received by DPA within six (6) months of the date that the service was delivered. Billing instructions for all services/supplies authorized for payment through DPA are contained in these procedures and/or in the DCFS Prior Approval Handbook.

The following procedures shall be used for completing and/or submitting bills to DPA for Medicaid ineligible services which are DCFS prior approved.

A) Psychological Services

When psychological services (tests, evaluations/assessments) are required for DCFS category 98 youth or for substitute caretakers/family members, approval must be authorized via the Field Office Supervisor or Unit Supervisor, unless court-ordered. A letter of referral shall be sent to the selected provider to explain the reason(s) for the requested services and a copy sent simultaneously to the appropriate Regional Medical Liaison. Psychological tests for the child and/or for family members/caretakers must be administered by a registered psychologist. Evaluations/assessments may be provided by persons other than registered psychologists and DPA Medicaid enrolled providers.

- o DCFS Category 98 Youth

  Payment can be authorized through DPA for evaluations/ assessments to diagnose a particular problem(s) to determine the child's functioning related to the suitability of the current placement or a new placement, but not ongoing therapy to treat the problem(s). An evaluation/assessment may be court-ordered or may be needed prior to or in conjunction with other psychological tests related to placement planning. The provider is limited to five (5) sessions to complete the assessment. This service is not available to a DCFS ward in the home of parent.

- o Family Member/Caretaker

  Psychological tests, evaluations/assessments may be provided to the child's substitute caretaker(s) or family member(s). Psychological tests for DPA 04, 06, 93 and DCFS 98 categorical cases are Medicaid eligible and may be billed as a 210 service. All other psychological services are Medicaid ineligible and must be billed as a code 211 service. These services must be placement related and conform with the criteria listed above.

  The provider billing form, DPA 2734, for psychological services shall be completed as noted for Medicaid eligible services in Section g. 2. above, with the following exception:

  Item 6 must contain the name of the individual to whom service(s) was provided and their relationship to the category 98 child when services are for family members and/or caretakers.

The C-13 shall be completed with the correct information. All entries shall be typed:

Item 1 - Enter name and location of state agency as Department of Public Aid, 628 East Adams, Springfield, Illinois 62708.

Item 2 -- Enter the provider's FEIN or Social Security number and zip code.

Item 3 -- Enter provider's name (last name first) and address (city, state, zip).

Item 10 -Enter the statement: "DCFS Authorized Services for: "child's name and category 98 case identification number. Directly below this information, enter the "Date(s) of Services", using only the first date of services in each month. DO NOT ENTER the name/type of test nor the fee from the DPA 2734, even though the test was administered to an individual other than the DCFS category 98 ward. DPA will complete the process for all psychological tests. Enter the DPA 2734 information (including charges) for psychological evaluations and assessments of the category 98 ward and/or other family member(s) on the C-13. Next, enter "Needs Code: 211" and "DO NOT RECOUP". (Use Needs Code 211 for all evaluations/assessments and for psychological tests when the individual is not active on a category 04, 06, 93 or 98 case.)

When completing the C-13, do not leave any spaces between the the provider's FEIN/Social Security number. Charges for more than one individual may be entered on the C-13 when the same psychological services are administered by the same provider. Only individual Needs Codes (210 or 211) can be entered on the C-13; they cannot be mixed. DCFS staff shall sign the C-13 in Item 26 as the Receiving Officer and the date of signature. The completed C-13 shall be attached to the DPA 2734 and any other documentation (out-of-state provider registration) and mailed to the Department of Public Aid, Bureau of Claims Processing, 931 East Washington, Springfield, Illinois 62763, Attention: Carole Luttrell.

Psychological tests must be administered by a registered psychologist; evaluations/assessments may be administered by a registered psychologist, therapist, counselor, practicing MSW, etc. When services are provided by an out-of-state provider, a copy of his/her state registration must be submitted with the bill.

Payment rates for psychological tests related to placement will be in accordance with DPA's Medicaid rate for Registered Psychologists. The C-13 (Invoice Voucher) and the DPA 2734 (Statement of Services/Supplies Provided) will be used to bill DPA. Evaluations/assessments can be paid at usual and customary rates.

When psychological services are Medicaid ineligible, they must be coded with NEEDS CODE 211 and PROCEDURE CODE 69999 on the C-13.

B) Optical Services

When a DCFS category 98 ward requires Medicaid ineligible optical services, the cost for such services or optical items will be paid from DCFS allocated funds through DPA's payment system. The ineligible service(s) requires DCFS prior approval. DPA no longer requires prior approval for eyeglasses but the limit of one (1) pair per twelve (12) month period is still effective. Although DPA has discontinued the prior approval process, DCFS will continue to utilize the prior approval process for a "required" second pair of eyeglasses. Additionally, DPA and DOC (Department of Corrections) have entered into an agreement for fabrication/distribution of eyeglasses for all medical card recipients and DPA has requested that DCFS comply with this change and use the DOC process whenever possible. When a situation occurs which requires that a DCFS ward be provided a second pair of eyeglasses immediately, DCFS Medical Liaisons shall utilize procedures for obtaining the needed eyeglasses through the most expeditious means.

The service provider must complete the DPA 1409 (Prior Approval Request) and submit it to the appropriate DCFS Regional Medical Liaison for review and subsequent approval or denial. When approved, the Regional Medical Liaison must assign a prior approval number and complete the approving authority's portion of the DPA 1409 as noted in the DCFS Prior Approval Handbook. Only approved DPA 1409's are to be submitted to DPA for processing. The mailing envelope must be clearly marked in red ink "DCFS Prior Approvals," and mailed to:

Illinois Department of Public Aid
Post Office Box 4071
Springfield, Illinois 62708

DPA will process the DPA 1409 and notify the medical provider by returning the original copy of the DPA 1409. This copy provides the prior approval number and notes that the bill can be submitted directly to DPA for payment. DPA will process the claim and reimburse the medical provider upon receipt of the appropriate billing invoice and any other documentation required.

If denied by the DCFS Region, the Medical Liaison must state the reason for denial in the Service Section of the DPA 1409; forward a copy of the DPA 1409 to the requesting Medical provider; notify the child's foster parent(s)/caretaker of the decision via the client notification letter and maintain a copy of the approved or denied DPA 1409 for audit and inquiry purposes.

C) Dental Services

When Medicaid ineligible dental or orthodontic services are needed for a DCFS category 98 ward, the dentist or orthodontist must submit a completed DPA 2242 to the appropriate DCFS Regional Medical Liaison. The DPA 2242 shall be reviewed for appropriateness and when approved, the Medical Liaison shall complete the DCFS authorization and submit it to:

Speci-Care Consolidated, Inc.
5400 North Milwaukee Avenue
Chicago, Illinois 60630

Speci-Care reviews and prices the service and submits the DPA 2242 to DPA for processing. DPA notifies the medical provider and the child's caretaker. Upon receipt of the notification from DPA, the provider can submit his/her bill directly to DPA for payment.

2) Payment Procedures - Non-Enrolled/Out-of-State Providers

Payment to non-DPA enrolled providers within the State of Illinois includes providers of psychological evaluations/assessments, optical and dental services. Out-of-state providers who are not DPA-enrolled may be paid for any DCFS prior approved service for the category 98 child. Payment can be made only by a C-13, even though the services may be Medicaid eligible. When the provider is not DPA enrolled, the payment cannot be processed through the Medicaid payment system. This includes both Illinois and out-of-state providers.

The request for service(s) must be submitted to the DCFS Medical Liaison for prior approval. When approval is granted, the provider shall be notified by DCFS. Following service provision, the provider must submit his/her charges on office letterhead/ stationery to the appropriate Regional Medical Liaison. Regional staff shall ensure that the C-13's are completed in accordance with instructions in these procedures and Section 5 of the Prior Approval Handbook. All C-13's must be submitted to DPA at P.O. Box 4071, Springfield, Illinois 62763, for processing and payment.

3) Pricing Procedures

A) All Medicaid Eligible Services and Items

All Medicaid eligible medical services and items shall be priced according to the Illinois Department of Public Aid's Title XIX structured rates. The Department of Public Aid issues rates for all covered medical services. DCFS staff shall compare the DPA established rate to the fee submitted by the provider. DCFS shall authorize payment for the lesser of the two charges since the DPA rate is the maximum that can be paid.

B) Non-Covered and Excluded Medical Services and Items

When a medical service or item is not Medicaid eligible under the Illinois DPA Title XIX Medicaid Program, DCFS shall authorize payment at the provider's usual and customary rate.

4) Regional Medical Payment Procedures for Ineligible Services/Wards Under DPA's Medical Assistance Program

The following services may be secured for any DCFS ward through Regional approval when such services cannot be obtained through the process described under the above Sections. Payment for these Regional approved services must be paid from DCFS Regional monies and not from DPA Medicaid or DCFS funds allocated to DPA.

A) Physician Services

Account Code:
001-41817-4400-08-00
001-41817-4400-09-00
684-41817-4400-00-99
001-41803-4400-02-00
001-41825-4400-01-00
001-41817-4400-05-00

Type Service Code:
1107 - Physician Services
1103 - Unwed Mothers
1101 - Abuse/Neglect
0303 - Adoption/Medical

Payment Documents: CFS 932-1 (Purchase Authorization) and DPA 2360 or PH0600

Approval Level: Regional Administrator or designee

Instructions: Bills/claims are to be priced in accordance with Section h, 3. Refer to Section d, 1 for description of physician services and Section d, 20 for description of Healthy Kids Program services.

B) Chiropractic Services

Account Code: 001-41817-4400-08-00
684-41817-4400-00-99
001-41803-4400-02-00
001-41817-4400-05-00

Type Service Code: 1113
0303 - Adoption/Medical

Payment Documents: CFS 932-1 (Purchase Authorization) and DPA 1443

Approval Level: Regional Administrator or designee

Instructions: Bills/claims are to be priced in accordance with Section h, 3. Refer to Section d, 2 for description of chiropractic services.

C) Dental Services

Account Code: 001-41817-4400-08-00
684-41817-4400-00-99
001-41803-4400-02-00
001-41817-4400-05-00

Type Service Code: 1110 - Orthodontic Services
1111 - Other Dental Services
0303 - Adoption/Medical

Payment Documents: CFS 932-1 (Purchase Authorization) and DPA 134

Approval Level: Regional Administrator or his designee

Instructions: Bills/claims are to be priced in accordance with Section h, 3. Refer to Section d, 3 for description of dental services.

D) Audiological Services

Account Code: 001-41817-4400-08-00
684-41817-4400-00-99
001-41803-4400-02-00
001-41817-4400-05-00

Type Service Code: 1119
0303 - Adoption/Medical

Payment Documents: CFS 932-1 (Purchase Authorization) and DPA 1443

Approval Level: Regional Administrator or designee

Instructions: Bills/claims are to be priced in accordance with Section h, 3. Refer to Section d, 4 for description of audiological services.

E) Podiatry Services

Account Code: 001-41817-4400-08-00
684-41817-4400-00-99
001-41803-4400-02-00
001-41817-4400-05-00

Type Service Code: 1112
0303 - Adoption/Medical

Payment Documents: CFS 932-1 (Purchase Authorization) and DPA 1443

Approval Level: Regional Administrator or designee

Instructions: Bills/claims are to be priced in accordance with Section h, 3. Refer to Section d, 5 for description of podiatry services.

F) Optician and Optometrist Services

Account Code: 001-41817-4400-08-00
684-41817-4400-00-99
001-41803-4400-02-00
001-41817-4400-05-00

Type Service Code: 1108 - Eyeglasses
1109 - Other Optical Services
0303 - Adoption/Medical

Payment Documents: CFS 932-1 (Purchase Authorization) and DPA 1443

Approval Level: Regional Administrator or designee

Instructions: Bills/claims are to be priced in accordance with Section h, 3. Refer to Section d, 6 for description of optician and optometrist services.

G) Therapy Services

Account Code: 001-41817-4400-08-00
684-41817-4400-00-99
001-41803-4400-02-00
001-41817-4400-05-00

Type Service Code: 1120
0303 - Adoption/Medical

Payment Documents: CFS 932-1 (Purchase Authorization) and DPA 1443

Approval Level: Regional Administrator or designee

Instructions: Bills/claims are to be priced in accordance with Section h, 3. Refer to Section d, 7 for description of therapy services.

H) Independent Laboratory Services

Account Code: 001-41817-4400-08-00
684-41817-4400-00-99
001-41803-4400-02-00
001-41817-4400-05-00

Type Service Code: 1114 - Eyeglasses
0303 - Adoption/Medical

Payment Documents: CFS 932-1 (Purchase Authorization) and DPA 2211

Approval Level: Regional Administrator or designee

Instructions: Bills/claims are to be priced in accordance with Section h, 3. Refer to Section d, 8 for description of independent laboratory services.

I) Medical Equipment/Supplies

Account Code: 001-41817-4400-08-00
684-41817-4400-00-99
001-41803-4400-02-00
001-41817-4400-05-00

Type Service Code: 1116
0303 - Adoption/Medical

Payment Documents: CFS 932-1 (Purchase Authorization) and DPA 2210

Approval Level: Regional Administrator or designee

Instructions: Bills/claims are to be priced in accordance with Section h, 3. Refer to Section d, 9 for description of medical equipment and supplies.

J) Medical Transportation Services

Account Code: 001-41817-4400-08-00
684-41817-4400-00-99
001-41803-4400-02-00
001-41817-4400-05-00

Type Service Code: 1402
0303 - Adoption/Medical

Payment Documents: CFS 932-1 (Purchase Authorization) and DPA 2209

Approval Level: Regional Administrator or designee

Instructions: Bills/claims are to be priced in accordance with Section h, 3. Refer to Section d, 10 for description of medical transportation services.

K) Pharmacies -- Drugs/Prescriptions

Account Code: 001-41817-4400-08-00
684-41817-4400-00-99
001-41803-4400-02-00
001-41817-4400-05-00

Type Service Code: 1115
0303 - Adoption/Medical

Payment Documents: CFS 932-1 (Purchase Authorization) and DPA 215

Approval Level: Regional Administrator or designee

Instructions: Bills/claims are to be priced in accordance with Section h, 3. Refer to Section d, 11 for description of pharmacies.

L) Inpatient Hospital Services

Account Code: 001-41817-4400-06-00
684-41817-4400-00-99
001-41803-4400-02-00
001-41817-4400-05-00

Type Service Code: 1104
0303 - Adoption/Medical

Payment Documents: CFS 932-1 (Purchase Authorization) and DPA 117

Approval Level: Regional Administrator or designee

Instructions: Bills/claims are to be priced in accordance with Section h, 3. Refer to Section d, 12 for description of inpatient hospital services.

M) Outpatient Hospital Services

Account Code: 001-41817-4400-08-00
684-41817-4400-00-99
001-41803-4400-02-00
001-41817-4400-05-00

Type Service Code: 1105
0303 - Adoption/Medical

Payment Documents: CFS 932-1 (Purchase Authorization) and DPA 1438

Approval Level: Regional Administrator or designee

Instructions: Bills/claims are to be priced in accordance with Section h, 3. Refer to Section d, 14 for description of outpatient hospital services.

N) Clinic Services

Account Code: 001-41817-4400-08-00
684-41817-4400-00-99
001-41803-4400-02-00
001-41817-4400-05-00

Type Service Code: 1106
0303 - Adoption/Medical

Payment Documents: CFS 932-1 (Purchase Authorization) and DPA 1438

Approval Level: Regional Administrator or designee

Instructions: Bills/claims are to be priced in accordance with Section h, 3. Refer to Section d, 15 for description of clinic services.

O) Psychological Services

Account Code: 001-41817-4400-08-00 Ward
684-41817-4400-00-99
001-41803-4400-02-00
001-41817-4400-03-00 Non-Ward

Type Service Code: 1001

Payment Documents: CFS 932-1 (Purchase Authorization) and DPA 2734

Approval Level: Regional Administrator or designee

Instructions: Bills/claims are to be priced in accordance with Section h, 3. Refer to Section d, 16 and e, 3J. for description of psychological services.

P) Nursing Services

Account Code: 001-41817-4400-08-00
684-41817-4400-00-99
001-41803-4400-02-00
001-41817-4400-05-00

Type Service Code: 1121
0303 - Adoption/Medical

Payment Documents: CFS 932-1 (Purchase Authorization) and DPA 1443

Approval Level: Regional Administrator or designee

Instructions: Bills/claims are to be priced in accordance with Section h, 3. Refer to Section d, 17 for description of nursing services.

Q) Psychiatric Services

Account Code: 001-41817-4400-06-00 (in-patient)
684-41817-4400-00-99
001-41803-4400-02-00
001-41817-4400-05-00
001-41817-4400-08-00

Type Service Code: 1003
0303 - Adoption/Medical

Payment Documents: CFS 932-1 (Purchase Authorization) and DPA 2360

Approval Level: Regional Administrator or designee

Instructions: Bills/claims are to be priced in accordance with Section h, 3. Refer to Section d, 18 for description of psychiatric services.

R) Funeral and Burial Expenses

Account Code: 001-41817-4400-08-00
684-41817-4400-00-99
001-41803-4400-02-00

Type Service Code: 1903

Payment Documents: CFS 932-1 (Purchase Authorization) and DPA 29 or DPA 94

Approval Level: Regional Administrator or designee

Instructions: Bills/claims are to be priced in accordance with Section h, 3. Refer to Section d, 21 for description and allowable rates for funeral and burial expenses.

5) Medical Payment Procedures for Abused/Neglected Children

A) Medical Care

Account Code: 001-41817-4400-08-00

Type Service Code: 1101

Payment Documents: CFS 932-1 (Purchase Authorization) and appropriate DPA billing form

Approval Level: Regional Administrator

Instructions: The only medical services that are covered are those medical services or items that are required by a physician or hospital to ascertain and treat the immediate symptoms related to the alleged abuse or neglect of the child.

On all temporary protective custody cases, the parents are financially responsible for the medical treatment of the child or children.

Medical providers are to be instructed that they are to first bill the parents, the parents' insurance company or DPA when the child is covered by DPA's Medicaid program.

DCFS is the payer of last resort and will only pay if reimbursement cannot be obtained from the sources listed above.

B) X-Rays

Account Code: 001-41817-4400-08-00

Type Service Code: 1101

Payment Documents: CFS 932-1 (Purchase Authorization) and appropriate DPA billing form

Approval Level: Regional Administrator

Instructions: X-rays may only be authorized by a physician as part of the physical examination of a child alleged to have been abused or neglected.

On all temporary protective custody cases, the parents are financially responsible for any x-rays taken.

Medical providers are to be instructed that they are to first bill the parents, the parents' insurance company or DPA when the child is covered by DPA's Medicaid program.

DCFS is the payer of last resort and will only pay if reimbursement cannot be obtained from the sources listed above.

C) Color Photographs

Account Code: 001-41817-4400-08-00

Type Service Code: 1101

Payment Documents: CFS 932-1 (Purchase Authorization) and appropriate receipts

Approval Level: Regional Administrator

Instructions: Any person required to investigate cases of suspected abuse or neglect may take or cause to be taken, at DCFS expense, color photographs of the area of trauma on the child (ward or non-ward) who is the subject of the investigation.

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OVERPAYMENTS AND REPAYMENTS

Section 359.100 Overpayments and Repayments

Overpayments to providers or to youth who receive their own payments (youth in independent living arrangements) usually occur because the **CFS 906 and 906-1, Placement/Payment Authorization Forms,** are not completed in a timely manner whenever there is a change in a child's placement, a change in the services provided or a change in the status of the home. If the change in placement is not processed in a timely manner, the provider (usually a foster parent or supervisory agency) continues to receive payments for a time period in which the child for whom the payment is made is no longer in that placement.

If a change in services provided is not processed in a timely manner, the provider will receive full payment for the new services, and a receivable for the original payment will be created. If there is a change in the license status of the home (no longer licensed) and the notification to the Central Office Payment Unit is not timely, another payment to the provider at the higher licensing rate could result.

If a provider receives a payment for which no service was rendered, or an overpayment is generated (provider was paid more than once for the same time period and the same type of service), the provider is liable for repaying that amount to the Department. The best way to prevent overpayments is to process changes in a child's placement or services by completing and submitting the **CFS 906** as soon as the placement changes.

The Office of Collections, located in the Department's Central Office, Springfield, is responsible for collecting any overpayments that have been made. The Office of Collections is notified of overpayments by means of a computer-generated billing statement that lists the child's name, I.D. number, the type of service, the amount of the overpayment and the month of service in which the overpayment occurred.

If the provider continues to receive payments from the Department for other children in placement, the amount of the overpayment will be automatically deducted from the next month's payment for those other children until the overpayment is repaid.

If the provider (or youth) no longer receives payments from the Department, the Office of Collections will notify providers (or youth) that an overpayment was made and request that the amount be repaid.

If providers who continue to provide care for other children for whom the Department is making payments, feel that the amount of the deduction will severely affect their ability to provide adequate care for the children remaining in their home, providers may notify their worker and request that an adjustment be made to the deduction. The deduction can be changed to monthly installments. The worker may negotiate a monthly amount with the provider based on the provider’s income, expenses and family size. The smallest amount of the monthly deduction is equal to at least 10% of the monthly payment amount received by the provider or 1/12th of the outstanding balance, whichever is **greater**.

When the worker and provider have agreed upon an amount, the worker must inform the Office of Collections by faxed memo, e-mail, or a call to the manager. The memorandum or e-mail must include the provider's name, provider I.D. number and the amount to be deducted monthly. The memorandum must be sent to the following address:

Manager, DCFS Office of Collections
406 East Monroe Station #433
Springfield, IL 62701
Phone: (217) 785-2535
Fax: (217) 782-4246

The Office of Collections will then data enter the amount indicated by the worker to be deducted from the current month's payment until the entire amount of the overpayment has been repaid.

The same process as above is to be followed for youth in independent living arrangements who have been overpaid and remain in an independent living arrangement.

If the provider who received an overpayment no longer has other children in care for whom payments will continue or a youth who received an overpayment is no longer in a paid independent living arrangement, the Office of Collections will notify the provider or youth in writing of the overpayment and a repayment schedule can be negotiated, taking into account their ability to repay based on income, expenses and family size.

When the Office of Collections has exhausted all means to recover overpayments from former providers or youth formerly in independent living arrangements, it will refer the matter to a private collection agency, the State Comptroller's Office, and the Office of the Attorney General.

DEPARTMENT OF CHILDREN AND FAMILY SERVICES

DISTRIBUTION: X and Z

POLICY GUIDE 2003.04

COMPREHENSIVE MEDICAID BILLING SYSTEM (CMBS)/ MEDICAID BILLING SYSTEM (MBS)

DATE: April 1, 2003

FROM: Jess McDonald

TO: Rules and Procedures Bookholders and DCFS and Medicaid Mental Health Service Providers

EFFECTIVE DATE: April 14, 2003

I. PURPOSE

In response to the requirements of the Health Insurance Portability and Accountability Act (HIPAA) this Policy Guide is being issued to describe the Comprehensive Medicaid Billing System (CMBS) and the Medicaid Billing System (MBS) and who must use it.

II. PRIMARY USERS

The primary users of this Policy Guide are all providers of 59 Ill. Adm. Code 132, Medicaid Community Mental Health (MCMH) Services and DCFS staff who receive, handle or transmit Part 132 billing information.

III. WHAT IS THE COMPREHENSIVE MEDICAID BILLING SYSTEM (CMBS) AND MEDICAID BILLING SYSTEM (MBS)

The DCFS Medicaid Billing System is the system through which Medicaid services are claimed to DCFS and the Illinois Department of Public Aid (IDPA). Providers submit claim data concerning MCMH Services provided to children under their contracts. Claiming occurs on a monthly basis via computer diskette through the Department's CMBS/MBS. This information is due no later than the last State of Illinois working day after the month in which service was provided.

The CMBS/MBS involves the use of a personal computer system by each agency for entry and correction of the claims to be submitted. DCFS provides this software free of charge to all agencies involved.

IV. USING THE CMBS/MBS

1) General Expectations of DCFS Medicaid Providers

Medicaid Community Mental Health Services providers submit billing data for the provision of Medicaid services to clients served under a DCFS Medicaid contract as follows:

a) **Submittal of Billings**: Medicaid providers submit billings for services in the format and medium specified by the Department no later than the last State of Illinois working day after the month in which services were provided. If the provider fails to submit the required billings, the Department reserves the right to suspend payment of the Medicaid portions of the rate, and/or to recoup monies paid to the provider for Medicaid services.

b) **Re-Submittal of Rejected Billings:** Medicaid providers re-submit billings previously rejected by either the Department or the Illinois Department of Public Aid for a correctable error on the next billing cycle due to the Department after the provider's receipt of notice of the rejected billings.

c) **Third-Party Payments**: All initial billings and previously rejected billings shall, as necessary, contain information concerning the amount of any payment the provider received from a third-party for services provided to an individual child.

2) Billings Processing By DCFS

When the Department receives billings from the provider as required above, the Department will edit the billings and return to the provider a file of records for correction within 15 days of the established cut-off dates. The cut-off date is the last working day of each month. Billings that are acceptable to this editing process will be forwarded to IDPA for approval.

3) Billing Requirements—Substitute Care Contracts

a) **Comprehensive Services**: Medicaid providers submit to the Department's Financial Management Division by the fifth working day of each month the Monthly Claim Statement listing of children served during the previous month and the inclusive list of dates of service for each child. The Monthly Claim Statement shall be the basis for determining the total amount of payment due to the provider based on the per diem rate. (The per diem rate consists of a Medicaid and Non-Medicaid/room and board portion.) Failure to comply with this section may result in payment interruption or contract termination. The provider shall submit Medicaid billings equal to or in excess of the total amount stated in the contract as support documentation for previous payments for Medicaid Community Mental Health Services. Therefore, the provider shall submit billings equal to or in excess of the number of days of care multiplied by the Medicaid portion of the rate.

Monthly payment for Comprehensive Mental Health/Rehabilitative Services will be made through the automated board payment system. The Department will prepare a reconciliation report for each DCFS Medicaid substitute care contract to verify that all billing information has been submitted and that any billings returned due to errors have been corrected and resubmitted.

If the provider fails to comply with the requirements for Comprehensive Services billing, service provision, or documentation requirements as outlined in the provider's program plan, the Department may revoke the provider's ability to provide Comprehensive Services. As a result, the Department may then require the provider to submit Fee-for-Service billing for Medicaid services.

The maximum Medicaid billings for which the provider may receive revenue is limited to the total days of care provided multiplied by the Medicaid per diem rate. Any Medicaid revenue received by a provider in excess of the reconciled Medicaid billings will be refunded to the Department or withheld from monies due the provider.

b) **Fee-for-Service**: Medicaid providers submit to the Department's Financial Management Division by the fifth working day of each month the Monthly Claim Statement listing of children served during the previous month and the inclusive list of dates of service for each child. The Monthly Claim Statement shall be the basis for determining the total amount of payment due to the provider based on the non-Medicaid portion of the full per-diem rate. Failure to comply with these requirements may result in payment interruption or contract termination.

The provider submits bills equal to or in excess of the total amount stated in the contract as payment for Medicaid Community Mental Health Services. Therefore, the provider shall submit billings equal to or in excess of the number of days of care multiplied by the Medicaid portion of the rate.

Payment for Medicaid Community Mental Health Services will be made on the basis of actual billing levels received and accepted by the Medicaid Billing System. The Department will prepare a reconciliation report for each DCFS Medicaid substitute care contract to verify that all billing information has been submitted and that any billings returned due to errors have been corrected and resubmitted.

For those billing months in which the billing reconciliation yields a net amount due to the provider, the Department will initiate a voucher payment. The maximum Medicaid billings for which the provider may receive revenue is limited to the total days of care provided multiplied by the Medicaid per diem rate. Any Medicaid revenue received by a provider in excess of the reconciled Medicaid billings will be refunded to the Department or withheld from monies due the provider.

4. Billing Requirements—Non-Substitute Care Contracts

a) **Counseling**: Medicaid counseling providers submit billing claims for services delivered to Medicaid eligible and non-Medicaid eligible clients served under the contract. Payments will be issued based on reconciled utilization information and a comparison with referral for service authorizations.

b) **SASS**: SASS providers submit bills for Medicaid Community Mental Health Services that equal or exceed a designated percentage of the maximum payable amount under the SASS contract. Payments will be issued based on the cash flow payment schedule outlined in the program plan.

V. BILLING PROCESSING

Once the CMBS/MBS billing diskette is sent by the provider to DCFS, the diskette is logged in as received by the Office of Contract Administration, Medicaid and Non-Board Services. The billing information is then uploaded on personal computer for initial verification of readable data. If the data is readable, a letter is sent to the provider confirming receipt and readability. The readable billing data is then batched and loaded to a DCFS mainframe "host" system. This billing data is then held until the regularly scheduled billing processing cycle. The mainframe and billing processing cycles are managed by the Department's Office of Information Systems. Reports by the Office of Information Systems are produced at several points in the billing processing cycle to provide a quality assurance check on the process. These reports serve to provide both alerts to any problems in the billing cycle (occurs two days before the final processing occurs) or actual print-outs regarding the results of the entire billing cycle.

Any reports that are generated are routed to the appropriate staff for monitoring/use. Report distribution includes the Department's Office of Financial Management for use in substitute care contract payment reconciliation and generation, the Office of Contract Administration for overall system integrity and interface with providers regarding the results of the billing cycles, and the Office of Contract Administration for payment and reconciliation on the SASS and Counseling contracts.

Any billings submitted via diskette that do not process cleanly through the billing processing cycle (e.g., because client names, ID's or other details are incorrect), are returned as errors to the Office of Contract Administration for error diskette generation. These error diskettes are returned to the providers for uploading onto their CMBS/MBS allowing for the error correction process described in section 1.b. above.

Once the billings are processed and verified as "valid" bills submitted by the provider, these valid bills are then submitted to the Illinois Department of Public Aid (IDPA) as Medicaid claims. IDPA then validates the claims against their system edits, and all valid claims are then submitted to the federal government for federal financial participation matching funds.

VI. QUESTIONS

MBS Technical Support

Computer system problems or software questions	(217) 524-3560

Office of Financial Management

Institution, Group Home, Foster Care & Independent Living payment questions	(217) 785-2704

Office of Contract Administration

Status of your billing or error diskette	(217) 524-3304
Counseling Contract billing or payment questions	(217) 557-2458
SASS contract billing or payment questions	(217) 785-0200

The Infant-Parent Institute

Medicaid Rule 132 interpretation or billing issues not specified above	
Champaign	(217) 352-4172
Matteson	(708) 503-8431

VII. FILING INSTRUCTIONS

File this Policy Guide with Procedures 359, Authorized Child Care Payments, immediately following page P359.100 (2).

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AUTHORIZED CHILD CARE PAYMENTS
February 20, 2009 - P.T. 2009.02

APPENDIX A, PAYMENT RATES
Effective October 1, 2008

I. Substitute Care Rates - Procedures 359.40

a) Relative Unlicensed Home Care

Foster Care - Standard of Need Monthly Rate
Type Service Codes: 3640, 6106, 6140, 2640

Size of Assist. Unit (# of wards in the home)	**Group I - Counties**	**Group II – Counties**	**Group III - Counties**
	Boone, Champaign, Cook, DeKalb, DuPage, Kane, Kankakee, Kendall, Lake, McHenry, Ogle, Whiteside, Winnebago, Woodford	Adams, Bureau, Carroll, Clinton, Coles, DeWitt, Douglas, Effingham, Ford, Fulton, Grundy, Henry, Iroquois, Jackson, JoDaviess, Knox, LaSalle, Lee, Livingston, Logan, Macon, Macoupin, Madison, McDonough, McLean, Mercer, Monroe, Morgan, Moultrie, Peoria, Piatt, Putnam, Rock Island, Sangamon, Stephenson, St. Clair, Tazewell, Vermilion, Wabash, Warren, Will Out of State	Alexander, Bond, Brown, Calhoun, Cass, Christian, Clark, Clay, Crawford, Cumberland, Hardin, Henderson, Menard, Edgar, Edwards, Fayette, Franklin, Gallatin, Greene, Hamilton, Hancock, Jasper, Jefferson, Jersey, Johnson, Lawrence, Massac, Marion, Marshal, Mason, Schuyler, Montgomery, Perry, Pike, Pope, Pulaski, Randolph, Richland, Saline, Scott, Shelby, Stark, Union, Washington, Wayne, White, Williamson,
1	$ 310.00	$ 295.00	$ 286.00
2	$ 612.00	$ 590.00	$ 572.00
3	$ 756.00	$ 735.00	$ 723.00
4	$ 972.00	$ 948.00	$ 916.00
5	$ 1155.00	$ 1120.00	$ 1090.00
6	$ 1236.00	$ 1212.00	$ 1182.00
7	$ 1330.00	$ 1288.00	$ 1253.00
8	$ 1424.00	$ 1392.00	$ 1352.00
9	$ 1530.00	$ 1494.00	$ 1458.00
10	$ 1640.00	$ 1610.00	$ 1530.00

Unlicensed caregivers are paid directly by the Department even if caregiver is supervised by a Purchase of Service Agency.

b) Licensed Foster Family and Relative Home Care (Effective October 1, 2008)

Licensed Department and Private Agency Maintenance Rates

Licensed Homes (Relative & Traditional Home Care)		Service Codes: 2902, 2940, 4102, 4140, 9101, 9102, 9106, 9140		
Age of Child	**Board**	**Clothing**	**Allowance**	**Total Rate/month**
0 – 11 mo.	$ 335.00	$ 37.00	$ 12.00*	$ 384.00
1 – 4 years	$ 337.00	$ 42.00	$ 13.00*	$ 392.00
5 – 8 years	$ 339.00	$ 56.00	$ 14.00	$ 409.00
9 – 11 years	$ 346.00	$ 65.00	$ 24.00	$ 435.00
12 and over	$ 354.00	$ 74.00	$ 43.00	$ 471.00

* Personal Allowance for children age 4 years and under is to be used by foster parents for incidentals (toys, rattles, etc.), which become the property of the child.

Licensed caregivers with Purchase of Service Agencies (POS) are paid by the POS agency.

Social Services Administrative Rates - Private Agency Foster Home Performance Contracts (PCC, PCS, PCD)

Private Agency Foster Home Rate Performance Contracts (PCC, PCS, PCD)		Service Codes: PCC: 2102, 2140, 2902, 2940 PCS: 0102, 0140, 4102, 4140 PCD: 0102, 0140, 9102, 9140		
Age of Child	**Maintenance Rate/month**	**PCC Soc.Serv. Administration** (2198)	**PCS Soc.Serv. Administration** (6188)	**PCD Soc.Serv. Administration** (6191)
0 – 11 mo.	$ 384.00	$ 724.10**	$ 516.78**	$ 724.10**
1 – 4 years	$ 392.00	$ 724.10**	$ 516.78**	$ 724.10**
5 – 8 years	$ 409.00	$ 724.10**	$ 516.78**	$ 724.10**
9 – 11 years	$ 435.00	$ 724.10**	$ 516.78**	$ 724.10**
12 and over	$ 471.00	$ 724.10**	$ 516.78**	$ 724.10**

Licensed caregivers with Purchase of Service Agencies (POS) are paid by the POS agency.

Includes **$19.79 per month for non-recurring incidentals for the following child expenses but not limited to:

1. Replacement clothing not covered by the monthly clothing allowance
2. Camp expenses
3. Lessons in recreation or artistic endeavors
4. Music instrument purchase or rental
5. Membership fees and equipment for Boy Scouts, Girl Scouts, 4-H, YMCA, YWCA,
6. School supplies
7. Gym shoes and equipment
8. Graduating expenses
9. School trips
10. Tutoring
11. Summer school fees
12. Travel unrelated to placement
13. Medical expenses not covered by the Healthy Kids Program
14. Interpreter/Translation Expenses

Performance Contract for Reunification Services / Aftercare

Name of Service	Rate Amount	Service Codes
Reunification Services		
Case Management	$ 638.98 per child per month	3033

The Department agrees to pay, upon request by the private agency and approval of the Department, for the following items:

1) Urine drops for parents/children through DCFS/OASA funded contractors that meet DCFS practice standards on when and to what extent urine drops should be utilized in the service planning and service provision process.

2) Out of state transportation when approved in advance and consistent with Department Rule 359 and in-state transportation over 50 miles one way from the Cook County border for Cook County cases only.

3) $36.90 per hour for ongoing and extraordinary services for children at home as defined in section IV.D. of the Cook County Relative Foster Care Performance Contract.

4) $124.03 per assessment for existing cases where the Department requests that a special assessment be conducted due to lack of information contained in the file/casework record.

Intensive Service Foster Care (Children no longer placed effective July 1, 2001)

Intensive Service Foster Care Service Codes: 0103, 0122, 0117, 9103, 9903	
Age of Child	**Rates/month**
0 – 11 mo.	$ 563.00
1 – 4 years	$ 574.00
5 – 8 years	$ 593.00
9 – 11 years	$ 618.00
12 and over	$ 654.00

Emergency Homes

Flat Rate Department Emergency Homes Service Codes: 0104, 0123, 9104, 9904	
Rates per day - for a maximum of 30 days	
$ 23.89	This rate does not include clothing and personal allowance.

Special Service Fee

Special Service Fee Name	**Maximum Per Month**	**Service Codes**	**Reason Code**	**Reason Name**
Child Behavior Problems	$ 100.00	0113	01	Child Behavior Problems
Child Physical Problems	$ 100.00	0113	02	Child Physical Problems
Unusual Transportation	$ 100.00	0113	03	Unusual Transportation
Ward and Infants	$ 149.00	0129	05	Ward with Infant – Pay FP
Ward Infant/Central Office	$ 107.00	0138	11	Ward with Infant – Pay Ward
Sibling Visitation Fee	$ 100.00	0146	07	Unsuprv Overnight Sib Vis
Supervision of Sibling Visits (Four hours maximum)	$ 25.00/hr	0176	15	Supervised Day Sib Vis
Transportation to/from Sibling Visits	$ 50.00	0165	16	Sibling Transportation
Adoption Assistance (before-11/28/95 only)	$ 100.00	0307	04	Other
Specialized Foster care Rate Adjustment (Central Office Use Only)	Na	0200	14	Specialized Foster care Rate Adjustment
SSI Special Needs Allowance (Central Office Use Only)	Na	0019	19	SSI Special Needs Allowance
Monitoring Phone Line	$ 50.00	0020	20	Probation Monitoring Line

Deaf Foster Care

Deaf Foster Care	Service Codes: 0105
Age of Child	**Rates/month*** **(Based on a 5-day school week)**
0 – 11 mo.	$ 120.00
1 – 4 years	$ 120.00
5 – 8 years	$ 120.00
9 – 11 years	$ 120.00
12 and over	$ 120.00

* An additional $25 is allowed if full time foster care is provided for a Maximum of $ 145

Home Studies (Client Assessment)

Name of Service	**Rate or Maximum Amount**	**Service Codes**
Case Assessment Fee	$124.03	0127, 2127

c) Adoption Assistance and Subsidized Guardianship

Adoption / Subsidized Guardianship Assistance Monthly Subsidy Rates (For adoptions / guardianships finalized prior to July 1, 2006)		
Age of Child	**Service Code: 0193, 0194, 0331, 0332, 0339 Rates/month**	**Service Code: 0333, 0334, 0150 Rates/month**
0 – 11 mo.	$ 360.80	$ 546.33
1 – 4 years	$ 369.01	$ 557.60
5 – 8 years	$ 384.38	$ 576.05
9 – 11 years	$ 410.00	$ 599.63
12 and over	$ 444.85	$ 634.48

Adoption / Subsidized Guardianship Assistance Monthly Subsidy Rates (For adoptions / guardianships finalized on or after July 1, 2006 and prior to October 1, 2008)	
Age of Child	**Service Code: 0373, 0374, 0346, 0347 Rates/month**
0 – 11 mo.	$ 372.00
1 – 4 years	$ 380.00
5 – 8 years	$ 396.00
9 – 11 years	$ 422.00
12 and over	$ 458.00

Adoption / Subsidized Guardianship Assistance Monthly Subsidy Rates (For adoptions / guardianships finalized on or after October 1, 2008)	
Age of Child	**Service Code: 0317, 0318, 0376, 0377 Rates/month**
0 – 11 mo.	$ 384.00
1 – 4 years	$ 392.00
5 – 8 years	$ 409.00
9 – 11 years	$ 435.00
12 and over	$ 471.00

II. Family Preservation and Auxiliary Services – Procedures 359.50

a) After Care

Name of Service	Rate or Maximum Amount	Service Codes
After Care Services		
Foster Care After Care	Rate negotiated by Regions	0108
Institution and Group H.	Rate negotiated by Regions	0205

b) Family Habilitation

Name of Service	Rate or Maximum Amount	Service Codes
Family Habilitation		
Family Habilitation	Not to exceed $ 18.51 per hour	0505, 0507
Medical Examination	$ 75.00	0503

c) Camping

Name of Service	Rate or Maximum Amount	Service Codes
Camping - Non-Wards for DCFS Intact Family Cases		
Camp Fees	$ 260.35 maximum per year per child	1506
Camp Clothing	$ 76.88	1204
Camp Supplies	$ 20.50	1508
Camp Transportation	DPA Rate	1405

d) Counseling/Advocacy Services

Family Psychological Evaluation		
Age of Child	**Rate or Maximum Amount**	**Service Codes**
0 – 5 years	$ 369.51	0441
6 – Adult	$ 712.64	0442

Family Psychological Evaluation		
Other Related Services		
Add-on for Home Based Assessment	$ 76.88	0445
Bonding Assessment	$ 717.50	0447
Psychologist Court Testimony	$ 75.00/hour, four hour maximum	0448

e) Home Studies

Name of Service	Rate or Maximum Amount	Service Codes
Court Ordered Marriage Dissolution Home Studies	$402.25 per study, plus $20.60 per hour for each hour of court testimony beyond the first hour. When two agencies or individuals share the responsibility for the home study due to differing geographic locations of the parties involved, the authorized rate for each shall be $250.00, plus $20.00 per hour for each hour of court testimony time beyond the first hour.	1690
Interstate Compact Home Studies	$364.24 per study, plus $20.60 per hour for each hour of court testimony beyond the first hour.	1691
Court Ordered Adoption Home Studies	$418.00 per study, plus $20.00 per hour for each hour of court testimony beyond the first hour.	1692
Court Ordered Supervised Visitation	$11.71 maximum that can be negotiated	1693

f) Family First Services

Name of Service	Rate or Maximum Amount	Service Codes
Family First Services		
Family Preservation Professional Services	Negotiated rate	3002
Professional and Paraprofessional Services	Negotiated rate based on 40% of fixed cost	3004, 3014*
Contractual Services	Rates should be reasonable and necessary for services. In no case shall the Department reimburse a contractual service rate at above the level paid by the general public for such services	3006, 3016

For Type Service Code **3014**, no special authorization is needed from the Office of Contracts & Grants to authorize service rates which were initially bid by the provider in response to a Request for Proposals.

III. Payments for Preparation for Independent Services - Procedures 359.60

a) Independent Living / Education & Transitional Services – effective October 1, 2008

Name of Service	Rate or maximum amount	Service Codes
Youth in employment, Youth in College and Scholarship		
Youth in Employment	$ 264.00 monthly grant (no new clients accepted after 12/31/05)	0701
Employee Incentive Program	$ 150.00 monthly grant (new program effective 1/01/06)	0708
Youth in College	$ 471.00 monthly grant	0720, 0725
Youth in Scholarship	$ 471.00 monthly grant	0801, 0806, 0706
Initial Expenses	Up to $200.00	0702, 0721, 0802

b) Preparation for Transitional Support Services (TLS)

Name of Service	Rate or maximum amount	Service Code
TLS Program - Most TLS service rates are negotiated by contract or at the prevailing rate with the exception of the following:		
Youth Learning Incentive	Up to $150.00	2012
Initial School Expenses	Up to $200.00	2014
Graduation Expenses	$300.00	2015
Field Trips	Up to $100.00	2018
Work Clothes and Supplies	Up to $75.00	2030
Camp Fee	$ 250.00 maximum/year/child	2028
Camp Supplies	$ 20.00 maximum/year/child	2028

IV. Children's Personal and Physical Maintenance – Procedures 359.70
DCFS Supervised Cases

Name of Service	Rate or maximum amount	Service Code
Initial Placement Clothing/Personal Hygiene Expenses		
0 to 2 years.	$ 130.18	1201
3 to 4 years	$ 146.58	
5 to 8	$ 169.13	
9 to 11	$ 206.03	
12 and over	$ 289.05	
Replacement Clothing	Maximum by ages per initial placement clothing $ 100.00 discharge from DOC $ 100.00 for unmarried mothers - maternity clothes	1202, 1205
F. Home Infant Equipment	$ 307.50 maximum	1315
Home of Relative Compliance Assistance	$ 250.00 per child per home	0139

Personal Allowance and Clothing for Children in Non-Title XIX Facilities		
DHS, Clothing and Allowance	$68.00 per month maximum	0207, 0216
DHS, Clothing, Allowance & School Fees for: IL Children's School & Rehabilitation Center; IL Children's Hospital School; IL School for Visually Impaired; IL School for the Deaf	$82.00 per month maximum	0207
Allowance for youth in Detention/Correction Centers	$24.00 per month maximum	0217, 0218
Camping Expenses – Wards		
Camp Fees	$ 260.35 maximum	1505
Camp Clothing	$ 78.93	1203
Camp Supplies	$ 20.50	1507
Camp Transport	CMS rate	1404
Overnight	By contract	1509
Cultural Enrichment		
Recreational/Artistic Lessons	Prevailing rate	1501
Musical Instrument Rental/Purchase	Prevailing rental rate, purchases generally should not exceed $205.00.	1502 1503
Recreational Membership Fees/Equipment	Prevailing rate	1504

Education Expenses - Most education rates are as needed with the exception of the following:		
School Supplies, Board Payment	$ 50.00 per year	1310
Summer School Supplies	$ 10.25 maximum	1306
Required Special Class Supp	At reasonable cost	1307
School Athletic Insurance	$ 100.00 maximum	1308
Graduation Expenses	$ 512.50 maximum	1302**
School Trips	$ 104.55 maximum	1305
Post-Secondary Preparation Fees	$ 200.00 maximum for school application fees $ 500.00 maximum for college room and board	1311 1311
Travel		
Placement, visits, return runaway, attend ACR	Follow travel guidelines AP #12 Reimbursement supported by documentation at CMS travel rate	1412,1409, 1410,1411, 1407, 1413

** Reimbursement for high school graduation expenses is also available to the POS Agencies (See Section 359.40 L)

V. Maximum Child Care Rates – Effective July 1, 2008

The following rates apply to all day care service codes except those negotiated by contract.

The rates listed below are the maximum rates that the Department will pay per day.

- For care provided less than 5 hours per day, use the part-day or school age-day rate.
- The School-Age rate refers to before and/or after school when school is in session.
- For care provided from 5 through 12 hours per day, use the full-day rate.

Providers cannot charge the State of Illinois rates that exceed the maximum allowed by the State and rates that are higher than those charged by the provider to the general public for similar services. This includes discounts such as multiple child discounts, staff discounts, full-week discounts, pre-pay discounts, and sliding fee scales.

a) Group IA

Counties: Cook, DeKalb, DuPage, Kane, Kendall, Lake, and McHenry

Type of Day Care	Ages	Full Day	Part Day	School Age (Before & After)
Licensed and License Exempt Day Care Centers	Under Age 2	$ 40.50	$ 20.25	NA
	Age 2	$ 34.20	$ 17.10	NA
	Age 3 +	$ 28.50	$ 14.25	$ 14.25
Licensed Day Care Home or Licensed Group Day Care Home	Under Age 2	$ 26.60	$ 13.30	NA
	Age 2	$ 25.60	$ 12.80	NA
	Age 3 +	$ 24.00	$ 12.00	NA

b) Group IB

Counties: Boone, Champaign, Kankakee, Madison, McLean, Monroe, Ogle, Peoria, Rock Island, Sangamon, St. Clair, Tazewell, Whiteside, Will, Winnebago, and Woodford

Type of Day Care	Ages	Full Day	Part Day	School Age (Before & After)
Licensed and License Exempt Day Care Centers	Under Age 2	$ 40.50	$ 20.25	NA
	Age 2	$ 32.00	$ 16.00	NA
	Age 3 +	$ 24.00	$ 12.00	$ 12.00
Licensed Day Care Home or Licensed Group Day Care Home	Under Age 2	$ 23.60	$ 11.80	NA
	Age 2	$ 22.60	$ 11.30	NA
	Age 3 +	$ 21.60	$ 10.80	NA

c) Group II

Counties: All other counties not listed in Groups IA & IB				
Type of Day Care	**Ages**	**Full Day**	**Part Day**	**School Age (Before & After)**
Licensed and License Exempt Day Care Centers	Under Age 2	$ 29.20	$ 14.60	NA
	Age 2	$ 24.80	$ 12.40	NA
	Age 3 +	$ 20.70	$ 10.35	$ 10.74
Licensed Day Care Home or Licensed Group Day Care Home	Under Age 2	$ 21.60	$ 10.80	NA
	Age 2	$ 20.60	$ 10.30	NA
	Age 3 +	$ 19.60	$ 9.80	NA

d) Licensed Exempt Day Care Homes, Non-Relative in Child's Home or Relative

Counties: All ages - All counties		
Type of Day Care	**Full Day**	**Part Day**
Licensed Exempt Day Care Home Non-Relative in Child Home or Relative	$ 12.75	$ 6.38

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APPENDIX B

FORMS USED WITH PROCEDURES 359

Precondition Forms

CFS 315*	Sibling Visitation Form
CFS 417	Referral Form for Psychological Evaluation
CFS 418	Level of Care Assessment Form
CFS 420-26	Attendance Exemption Request Form (Day Care)
CFS 438	Scholarship Program Student Application
CFS 470-A	Adoption Assistance Program Child's Summary
CFS 470-B*	Adoption Assistance Information and Application Form
CFS 470-C*	Agreement for Adoption Assistance
CFS 470-D*	Adoption Assistance Agreement Letter
CFS 497*	Service Plan
CFS 888-3	Case Action Form
CFS 932C	Infant Care Equipment Grant Application
CFS 932D	Infant Care Equipment List
CFS 940-1	Referral for Purchase of Care for an Unmarried Mother
CFS 968-18	Day Care Provider Purchase of Service Contract
CFS 968-22	Program Plan Adoption Services
CFS 968-45	DCFS Contract Boilerplate
CFS 968-54	Performance Contract Reunification Budget Summary
CFS 968/Supp D	Application for Subsidized Child Care
CFS 968/Supp E	Day Care Program Plan narrative
CFS 968/Supp F	Site-Administered Employment-Related Child Care Contract Exhibit
CFS 1410	Registration/Case Opening
CFS 1411	Eligibility I (Financial Data Sheet)
CFS 1429	DCFS Residential Placement Review Form
CFS 2000	Request for Child Care Service and Registration
CFS 2002*	Foster Parent Application for Employment-Related Day Care
CFS 2003	On-Site Visit - License Exempt Day Care

Payment Documents

CFS 402	Request for Vital Record Verification
CFS 420-21a	Day Care Monthly Enrollment Report
CFS 420-21b	Monthly Enrollment Report
CFS 901	Claim Voucher - Agency
CFS 902	Exceptional Payment Requests
CFS 906	Placement/Payment Authorization Form (Department Foster Care)
CFS 906-1	Placement/Payment Authorization Form (Private Agency, Institution & G. H.)
CFS 906-4	Special Service Fee and Payment Extension Form
CFS 932	Purchase Authorization
CFS 1042	Billing Summary
CFS 1042F	Family Preservation and Reunification Billing Summary
CFS 1042N	Norman Emergency Assistance Billing Summary
C-10	Travel Voucher
C-13	Invoice Voucher

APPENDIX C

EXCEPTIONAL PAYMENTS

a) The purpose of an exceptional payment is to provide regions with a method of payment for items not otherwise covered under current payment procedure or for items which exceed the authorized rate. The following procedures apply to all special payments.

1) The Regional Administrator is responsible for approving all exceptional payment requests. Exceptional payments must be approved prior to obligation of funds for the purchase.

2) The Regional Administrator or designee may authorize exceptional payments up to a limit of $1,000.00 per incident.

3) The Regional Administrator **may not grant approval** of an exceptional payment unless payment is for an open child/family case and the requested purchase is in accordance with the goals and objectives of the service plan or in the best interests of the child.

4) The Regional Administrator **may not grant approval** of an exceptional payment for medical costs unless the child is a ward of the Department or subject to a CANTS investigation and the services/equipment are not available through the medical card.

5) The Regional Administrator **may not grant approval** of an exception to rates for providers such as foster parents, group homes, institutions, homemakers, advocates, etc. or any rate established by contract.

6) In cases where exceptions to the above (2), (3) and (4) paragraphs are needed, the Regional Administrator may recommend an exceptional payment which is subject to review and approval of the Executive Deputy Director.

b) Authorizations for exceptional payment approvals will be made **on CFS 902, Exceptional Payment Request, and CFS 888-3, Case Action Form**. The requestor shall complete the **typed** form in quadruplicate. When approved, one copy may be filed in the child's regional file, one copy will be submitted to the Supervisor, General Accounting and Reporting, 406 East Monroe, Station #450, Springfield, Illinois 62701, **and one copy will be attached to the voucher/payment request when submitted to Central Office for payment**.

c) Staff of the Office of Program Operations, Field Operations, Bureau of Program Support, and the Office of Audits will conduct periodic reviews regarding the necessity and validity of the exceptional payment approval process.

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APPENDIX D

DAY CARE EXEMPTION IN ATTENDANCE POLICY

The following procedures specify the objectives of the attendance exemption policy, types of exemptions that are allowed, and instructions regarding how and when to use/obtain an attendance exemption.

I. Contractual Days and Reimbursement

The maximum number of days per year which the Department will reimburse for any one child is 256. This maximum is applicable to all types of facilities (i.e., day care homes, day care centers, in-home care, and care by a relative) and for all types of day care (i.e., Foster Parent Day Care, Protective and Family Maintenance, and Infant Mortality Reduction Initiative).

The attendance rate for day care centers is 80%. This means that a day care center will be reimbursed for all eligible child days only if the attendance days of eligible children are at least 80% of the eligible days for these children. This is applicable for all types of day care with the exception of some Site Administered programs, serving unstable populations, where a lower percentage has been negotiated.

II. Objectives and Types of Exemptions

Exemptions to the attendance requirements are aimed at the following objectives:

- To encourage funded day care centers to provide day care services even during extraordinary circumstances.

- To lessen the financial impact of certain events which are beyond the control of the day care center.

The two types of exemptions are as follows:

A. Group Exemptions

1. A snowfall such that schools, offices and/or industries are closed for the day.

2. A natural disaster, such as a flood or a tornado.

3. A mechanical breakdown, such as a boiler breakdown, electrical outage, frozen water pipes, etc., which is of long enough duration to inhibit providing services.

4. An epidemic, such that at least 50% of the children are absent on a certain day(s) during the month. This includes common illness such as chicken pox, flu, common cold, head lice, etc. (When a case of communicable disease occurs in a day care center, this fact shall not be considered a reason for the facility to close, except in the event of an emergency.)

5. Other extraordinary circumstances which will be individually examined by the appropriate Regional Day Care Unit.

B. Individual Exemptions

1. Excused absences such as vacations, court ordered visitation, hospitalization or an extended illness in excess of five days.

2. Swing shift workers who may not work a five-day week every week.

III. Calculations and Procedures

A. Group Exemptions

1. Determining Eligibility

Substantially less than normal attendance occurs when the attendance of subsidized children on a particular day(s) is less than 50% of the average attendance of subsidized children for that month. To determine eligibility for the attendance exemption, the average attendance is calculated excluding the date(s) for which the attendance exemption is requested. After average attendance has been determined, the attendance percentage for the day(s) for which a waiver is requested is then calculated. This is done by using the attendance of subsidized children on that day, divided by their average attendance. (The Attendance Exemption Request Form outlines the method of calculations in greater detail.)

2. Request/Approval of an Attendance Exemption

The Regional day care staff must be notified within five (5) working days of such an event for which the day care center is requesting an attendance exemption. At the end of the month a **CFS 420-26, Attendance Exemption Request Form** must be completed in duplicate by the day care center. The original **CFS 420-26** must be submitted to the Regional day care staff prior to submitting the Monthly Enrollment Report. (The copy of the **CFS 420-26** should be retained by the center.)

Any documentation that the center has regarding the occurrence of an extraordinary event should be submitted along with the **CFS420-26**. Such documentation may include newspaper articles on school closings due to snow, natural disasters or epidemics. The Regional day care staff will approve or deny the Attendance Exemption Request (via the **CFS 420-26**) and return the form to the center. The center must submit a copy of the approved form when a Monthly Enrollment Report is submitted.

3. Attendance Calculations

a. If approval is granted for an attendance exemption and the center was open on that date to provide services, an attendance day will be credited to each subsidized child claimed on the Monthly Enrollment Report, regardless of whether that child was in attendance or not.

b. If approval is granted for an attendance exemption and the center was closed, the number of children credited with an attendance day and an eligible day on the Monthly Enrollment Report for that day will equal the average attendance of the month as computed earlier.

c. If approval is granted for an attendance exemption, the approval must be in writing from the Regional day care staff and must be received by the day care center before the Monthly Enrollment Report is completed.

The person completing the Monthly Enrollment Report should include (on line 8) the date(s) for which an exemption was approved. The Regional day care staff must send a memorandum that documents the approval of an attendance exemption to for the Regional staff person responsible for POS billings. The memorandum must be received before payment can be authorized and must list each date that was approved during a particular month.

B. Individual Exemption

1. Excused Absences

Individual excused absences are permitted for events over which the center has no control. Such circumstances include: vacations, court ordered visitations, and extended (over five days) illnesses or hospitalization. An exemption is also permitted for children of swing shift workers whose scheduled enrollment may not be for five (5) days every week. (Scheduled enrollment is the number of days that a child is expected to be in attendance.)

2. Documentation

Required documentation for absences, with the exception of illness, is a signed statement from a parent. Absences involving an illness or hospital stay of more than five (5) days require a signed statement from the child's parents or guardian. The statement must, at a minimum, include the date, the child's name, date of absence, reason for the absence and a signature. The original statement must be maintained in the child's file at the center. Failure to maintain the documentation for the absence will result in non-payment by the Department.

If the attendance exemption is used for swing shift workers, a statement with the above information is required at the end of each month. The statement must list the days that the parent worked during the month.

3. Attendance Calculations

The exemption process is designed to yield the new number of days eligible; therefore, the number of days allowed for the excused individual absence will be subtracted from the number of days the child would normally have been eligible. This number will be used when completing the eligible days portion of the Monthly Enrollment Report.

When the Monthly Enrollment Report is completed, an asterisk (*) should be placed by the name of the child for whom the individual excused absence is being given.

IV. Examples

The following examples may be used by the day care center to determine if an attendance exemption should be requested.

A. Group Exemptions

1. Center Closed

A center closes for a day due to a blizzard. The center informs the Regional day care staff within five (5) working days and submits a **CFS 420-26** along with any documentation that the center has. If the request is approved, the center will add to each child (equal to that month's average daily attendance) an attended and an eligible day for each approved attendance exemption day when completing the Monthly Enrollment Report.

2. Center Open

A center experiences an outbreak of the flu, but remains open to serve the healthy children. The center informs the Regional day care staff within five (5) working days and submits a **CFS 420-26** along with any documentation that the center has. (A **CFS 420-26** has been attached to show examples of the calculations used.) If the request is approved, the center will credit each subsidized child enrolled with an attendance day when completing the Monthly Enrollment Report.

B. Individual Exemptions

1. Vacation

Naomi Jones' mother has a one week vacation. Naomi does not attend the center during this time but stays home with her mother. During the month, Naomi also missed one other day. Therefore, she was at the center for a total of 15 days.

The center applies for an individual excused absence exemption by using the following procedures:

a. Obtain a signed statement from the mother. The statement shall contain the date, the child's name, the date(s) missed and the reason for the absence (i.e., vacation).

b. Calculate a new number of eligible days for Naomi. She would have been eligible for 21 days, but had a five day individual excused absence. Therefore, the five days are subtracted from the 21 days to arrive at 16 days eligibility.

c. Complete the Monthly Enrollment Report: Place an asterisk (*) next to Naomi's name; put 15 under days attended and put 16 under days eligible.

d. Retain the original statement in Naomi's file.

2. Swing Shift Worker

Steve Smith's mother is a swing shift worker. Therefore, at the end of each month she must complete a statement giving the days she worked during

that month. Her schedule for this month allows her four weekdays off.

At the end of the month, the center shall:

a. Calculate the eligible days for Steve. If he had attended every weekday that month, he would have had 22 days attendance but due to his mother's work schedule he missed four days. Therefore, the four days are subtracted from the 22 to arrive at 18 days eligibility.

b. The Monthly Enrollment Report will show 18 days attendance and 18 days eligibility. An asterisk (*) must be placed next to Steve's name.

c. Each statement from Steve's mother must be retained in his file.

EXAMPLE

ATTENDANCE EXEMPTION REQUEST FORM

Information

1. Date(s) for which an exemption is requested: January 12, 1981
2. Reason for the exemption request: Flu outbreak
3. Documentation of the reason: Newspaper articles on outbreak in public schools.
4. Was the day care center open? Yes X No

Calculations

Fill in the daily attendance of the DCFS funded children only, for each service day of the month, by date. Circle the day or days for which an exemption is requested.

SERVICE DAY	DATE	ATTENDANCE	SERVICE DAY	DATE	ATTENDANCE
1	01/02	30	13	01/20	44
2	01/05	45	14	01/21	43
3	01/06	43	15	01/22	44
4	01/07	42	16	01/23	45
5	01/08	44	17	01/26	45
6	01/09	40	18	01/27	43
7	01/12	10	19	01/28	44
8	01/13	30	20	01/29	45
9	01/14	38	21	01/30	45
10	01/15	42	22	---	--
11	01/16	45	23	---	--
12	01/19	44	24		

Add the attendance of all the dates not circled and divide by that number of days to calculate the average attendance for the month.

Total of Attendance Days Not Circled = 851 = 43 Average Attendance for Month Total Number of Service Days Not Circled 20

The attendance for the date(s) an exemption is requested is: 10

Exemption Date Attendance = 23%

Day Care Center Name: Jones Day Care Center
Day Care Center Phone Number: 999 123-4567
Person Completing Form: Anybody Jones
CFS 420-26

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APPENDIX E

EMPLOYMENT-RELATED DAY CARE FOR FOSTER PARENTS

This appendix describes how to pay for employment-related day care for foster parents.

I. Who Is Eligible?

All Department wards in Department or private agency foster care or relative home care are eligible if they require day care services due to the employment or training leading to employment of the caretaker or for other documented and necessary reasons such as temporary incapacitation of the foster parent. Payment for day care will be available to employed single parent foster homes or relative homes, as well as two parent foster homes in which both parents work. Day care for a reason other than employment or training requires documentation justifying that day care is absolutely necessary, such as a letter from physician, court order, etc.

II. Types of Day Care

The types of day care which may be authorized are licensed day care centers and homes, home networks, and license-exempt day care centers, homes, baby-sitters and relatives. The rates are the same as the regular day care rates listed in Appendix A of this Procedure. Foster parents or relative caretakers may choose their own providers with the assistance of their Permanency Worker and/or regional day care personnel. The Permanency Worker will ensure that any license-exempt care being utilized is appropriate for the child in accordance with the instructions described in paragraph IV below.

While it is not expected that there will be many requests for employment-related day care for intensive, specialized, emergency and foster care treatment homes, nevertheless, the possibility exists. Special care should be taken when choosing a day care provider for children in these types of placements due to the special needs of these children. The day care provider must be able to meet needs arising from any physical, mental or behavioral impairments or conditions the children might have. For children with special needs, an exception to the day care rate may be requested when the foster parent(s) is unable to obtain day care within the Department rate. Regional Administrators may approve exceptions for open family maintenance/protective services cases, infant care, and care for children with special needs if documentation of the need for exception is secured and maintained in the contract file. Documentation must indicate that the provider is the sole source or others could not be located at the state rate and must be signed by the Regional Administrator.

III. Application for Day Care

When a foster parent or relative caregiver requests day care services for Department wards in their care because of employment or training leading to employment, the Permanency Worker shall complete the first page of the **CFS 2000, Day Care Services Application** and give the foster parent/relative caregiver the **CFS 2000, Parts I and II**. The Permanency Worker shall submit the completed form to Regional day care staff for processing. Payments will be made directly to the provider.

IV. License Exempt-Day Care

When a foster parent/relative caregiver's plan involves a license-exempt day care provider, the Department or private agency worker shall complete the **CFS 2000, Part III** and shall make a home visit to the day care provider in order to complete a **CFS 2003, On-Site Visit – License-Exempt Day Care**. The **CFS 2003** is used to gather basic information about the day care provider's household and physical environment, to obtain the authority to conduct CANTS background checks on all household members and any assistants or substitutes the provider may use, and to ensure that the home meets basic health and safety requirements. If day care is to be provided in the home of the foster parents, the visit with the day care provider may be conducted in the home of the foster parent or relative caregiver.

The Permanency Worker is to complete a CANTS check on the day care provider and on each adult member of the provider's household. If day care is to be provided in the foster parent's home by a baby sitter, CANTS checks only need to be completed on the baby sitter and any assistants or substitutes. In this instance, there is no need to conduct CANTS checks on other members of the day care provider's household unless they are involved in providing day care. The results of the CANTS check shall be documented in the child's record on a **CFS 492, Case Entry**. The **CFS 2003** will be filed in the child's case record. If more than one child is receiving care, a copy of the **CFS 2003** shall be made and filed in the additional child's case record.

If, in the opinion of the child's worker after completing the home visit, the CANTS check, and the **CFS 2003**, the day care setting is not a suitable day care provider for the foster child, the worker shall advise the foster parent and the Regional day care staff that the Department will not pay for day care services from this provider. A copy of the **CFS 151, Notice of Decision,** shall simultaneously be forwarded to the Regional day care staff. The foster parent will be given 14 days to find another day care provider and submit another request for funding. Referrals to the Child Care Resource and Referral network may be helpful in locating another provider.

After the child's worker has approved the license-exempt day care provider, the worker will make semi-annual visits to the exempt provider while the child is present to determine continued suitability of the child care arrangement. More frequent visits shall be made, if problems have been identified. Each visit is to be documented in the child's case record on the **CFS 492.**

APPENDIX F

TYPE SERVICE CODES

0019 – SSF - SSI SPECIAL NEEDS ALLOWANCE

A special service fee initiated by Central Office upon notification from the Children's Accounts Unit.

0100 – SSF - CHRISTMAS BONUS

Payments to DCFS supervised foster homes for child's Christmas gift.

0101 – DEPARTMENT BOARDING HOMES

Payment for regular Department boarding homes that are foster homes supervised by DCFS.

0103 – DEPARTMENT INTENSIVE FOSTER CARE

Payments for children with specialized needs due to physical, mental or behavioral impairments or conditions, or for pregnant girls or young parents who are in need of specialized training in parenting skills, child development, money management, and self-sufficiency.

0106 – DEPARTMENT RELATIVE FOSTER CARE

Payments for relative boarding home care (excluding parents and guardians) DCFS has legal responsibility for children.

0108 – FOSTER CARE AFTERCARE

Payment for the continuation of social services to a child and family when placed from Department or private agency aftercare for after care in licensed child welfare agencies under DCFS contract. Rate negotiated by contract.

0109 – AGENCY SPECIALIZED FOSTER CARE (OPEN TO INTAKE CONTRACTS)

Payments to licensed child welfare agencies for care to children with physical, mental or behavioral conditions.

0111 – MASTER FOSTER PARENT

Payment to master foster parents who will provide supportive and instruction services to licensed foster parents within a specific geographical area.

0112 – FOSTER PARENT TRAINING AND RECRUITMENT

Payments for training and recruitment of foster parents negotiated with an individual or agency demonstrating expertise in the field. Rate negotiated by contract or agreement.

0113 – SSF – FOSTER CARE

Payments for Special Service Fee approved for children with type service codes 2102, 2140, 0101, 0102, 0103, 0106, 0107, 0115, 0122, 0140, 0151, 0152, 0153 and 0154 when they require extraordinary expenses.

0116 – TRAINING REIMBURSEMENT FOR FOSTER CARE

Payment of registration fees, in-service training sessions and related travel costs, including babysitting for the children of individual DCFS foster parents or relative caretakers reimbursed by voucher with adequate documentation. (receipts showing proof of expenditures)

0117 – INTERMITTENT SPECIALIZED FOSTER CARE

Payment for weekend visits or vacations for children placed in specialized foster care from state-funded facilities (DHS), which receive a clothing allowance for the child or respite care for foster parents.

0118 – CASE MANAGEMENT SERVICES ONLY

Payment to private agencies or individuals for the delivery of specifically identified services (except aftercare or reunification) to children.

0119 – FOSTER CARE SUPERVISION

Payment to private agencies for providing supervision and social services.

0120 – INTERMITTENT NON-CONTRACTED FOSTER CARE

Payment for weekend visits or vacations for children placed in regular Department foster care from state-funded facilities (DHS) that receive a clothing allowance for the child or for respite care for foster parents.

0121 – C-13 PRIVATE AGENCY BOARDING HOMES

Payments to private agency boarding homes paid on C-13.

0127 – CASE ASSESSMENT FEE

Payment to private agency to perform client assessments.

0128 – FINANCIAL ASSISTANCE TO NEW FOSTER PARENTS

Payment for financial assistance to new foster families who experience cash-flow problems in order to meet the needs of the children placed in their care. Purchase authorizations are issued only after all other alternatives have been considered and rejected.

0129 – SSF – WARD WITH INFANT – CAREGIVER EXPENSES

Payment for special service fee initiated by the worker for a foster parent who incurs extraordinary expenses related to the costs of caring for a ward's child in their home. The ward must be the full time custodial parent.

0130 – DIRECT PAYMENT OF FOSTER PARENT TRAINING EXPENSES

Direct payments to providers for cost of registration fees, in-service training sessions and related travel costs, including babysitting for the children of individual DCFS foster parents or relative caregivers.

0131 – CRISIS SUPPORT SERVICES FOR DCFS FOSTER PARENTS

Payment for counseling, consultation, and other similar supportive services provided on behalf of DCFS supervised foster parents and approved relative home caretakers to avoid placement disruption in times of crisis related to the behavior of the ward or to the ward's biological family.

0132 – RESPITE AGENCY HOMEMAKER SERVICES FOR FOSTER PARENTS

Payment for respite care provided to licensed DCFS parents in times of crisis to prevent placement disruption. Example of respite care, round the clock homemaker or childcare services.

0133 – RESPITE INDIVIDUAL HOMEMAKER SERVICES/CHILDCARE FOSTER PARENTS

Payment for respite care provided to licensed DCFS foster parents in times of crisis to prevent placement disruption. Example of respite care, round the clock homemaker or childcare services.

0134 – ACCREDITATION – SURVEY AND EXPENSE COSTS

Lump sum to private agencies when they attain accreditation.

0135 – ACCREDITATION – CORRECTIVE ACTION COSTS

0138 – SSF – WARD WITH INFANT – WARD EXPENSES

Payment for special service fee initiated by Central Office after a worker notifies the Central Office of a parenting ward with children who reside with the ward. Used by the ward for care of the child. The ward must be the full time custodial parent.

0139 – HOME OF RELATIVE – COMPLIANCE ASSISTANCE

0140 – AGENCY RELATIVE FOSTER CARE

Payment to private agency for relative foster home care. Always used for new placements in HMR foster homes.

0143 – AGENCY SPECIALIZED FOSTER CARE (CLOSED TO INTAKE CONTRACTS)

Payments to licensed child welfare agencies for care to children with physical, mental or behavioral conditions. Specific to specialized contracts that are closed to intake.

0146 – SSF - SIBLING VISITATION – OVERNIGHT

Payment for special service fee per month to foster parents for hosting an overnight visit for the brothers and sisters of the children in their care.

0150 – SUBSIDIZED GUARDIAN SUBSIDY – INTENSIVE

Payment for monthly subsidy amount if the child was receiving any type of specialized foster home payments prior to the transfer of guardianship.

0157 – SSF – FAMILY REUNIFICATION SERVICES
(no new requests granted effective 12/01/04)

Payment for special service fees available based upon special needs including extraordinary transportation, ongoing unique costs, etc.

0163 – PREGNANT PARENTING TEEN – I.L.O.-18/OVER

Pregnant parenting teen program for wards with disabilities.

0164 – PREGNANT PARENTING TEEN/ADMINISTRATION

Administrative cost of pregnant parenting teen programs.

0165 – SSF - SIBLING VISITATION – TRANSPORTATION ONLY

Payment for a special service fee authorized to reimburse foster parents and relative foster parents to support sibling visitation through transportation.

0176 – SSF - SIBLING VISITATION – DAYTIME SUPERVISION

Payment for special service fee authorized to reimburse foster parents and relative foster parents to support sibling visitation through supervision.

0186 – SUBSIDIZED GUARDIAN SUB-REL-MANUAL CALC

Payment for monthly subsidy amount if the child was receiving any type of specialized, relative foster home payments prior to the transfer of guardianship.

0189 – SUBSIDIZED GUARDIAN SUBSIDY – TRAD - SPECIAL RATE

Payment for monthly subsidy amount if child was receiving any type of specialized, traditional foster home payments prior to the transfer of guardianship.

0190 – FOSTER CARE/ADVANCE PAYMENT

Advance payment to foster care provider as negotiated by contract.

0191 – CURRENT FUNDING PAYMENT

Payment for estimated monthly payment prepared by the Budget and Finance Division.

0193 – SUBSIDIZED GUARDIAN SUBSIDY (PRIOR TO 7/1/06) – RELATIVE

Payments applicable to the Subsidized Guardianship program for subsidy paid to a relative guardian.

0194 – SUBSIDIZED GUARDIAN SUBSIDY (PRIOR TO 7/1/06) – TRADITIONAL

Payments applicable to the Subsidized Guardianship program for subsidy paid to a traditional guardian.

0195 – EXTENDED FAMILY SUPPORT GRANT

0196 – EXTENDED HMR FAMILY AMOUNT

0197 – EXTENDED SERVICES CASH ASSISTANCE

0199 – MISCELLANEOUS FOSTER CARE NOT CLASSIFIED ELSEWHERE

Payments for foster care expenses not included or defined in other service codes.

0200 – SSF - SPECIALIZED RATE ADJUSTMENT (CENTRAL OFFICE ONLY)

Additional board payment made to foster parents to bridge the transition and meet the special needs of children.

0201 – PRIVATE INSTITUTIONS

Payments to a licensed private child care institution.

0203 – PRIVATE GROUP HOMES

Payments to a licensed private group home.

0204 – SUPERVISED INDEPENDENT LIVING

Payment for supervision of youth in independent living arrangements by licensed child welfare agencies as negotiated by contract.

0205 – INSTITUTION/GROUP HOME AFTERCARE

Payment to a licensed child welfare agency for the continuation of social services to a child and family when placed from a child care institution or group home for aftercare.

0207 – DHS INSTITUTION –ALLOWANCE

Payment for personal allowances and clothing monies for wards in Title XIX certified facilities.

0210 – CRISIS INSTITUTIONAL CARE

Payment for short-term intervention placement of children.

0211 – PLACEMENT PREVENTION AND REDUCTION

Payment for provider services to maintain a child with family deterring the placement of child in residential care. Accomplished through building of social, educational and emotional strengths within the family through the utilization of community resources.

0213 – C-13 PRIVATE INSTITUTIONS

Payments to a licensed childcare institution using C-13 voucher as payment method.

0214 – C-13 PRIVATE GROUP HOME

Payments to a licensed private group home using C-13 voucher as the payment method.

0215 – C-13 SUPERVISED INDEPENDENT LIVING

Payment for supervision of youth 16 through 20 years of age in independent living arrangements by licensed child welfare agencies as negotiated by contract.

0218 – ALLOWANCE – DETENTION FACILITY

Payment for personal allowances and clothing monies for wards in Non-Title XIX detention facilities.

0221 – EMERGENCY SHELTERS – INSTITUTIONS

Payments to a licensed institution for providing emergency shelter.

0222 – EMERGENCY SHELTERS – GROUP HOME

Payments to a licensed group home for providing emergency shelter.

0224 – EDUCATIONAL SERVICE – WARDS IN PLACEMENT

0240 – OUT OF HOME INSTITUTION/GROUP HOME – NON-MEDICAL

Requires Director's Office approval.

0244 – OUT OF HOME – SUPERVISED INDEPENDENT LIVING – NON-MEDICAL

Requires Director's Office approval.

0267 – PREGNANT PARENTING TEEN – RESIDENTIAL

0268 – TLP – TRANSITIONAL LIVING PROGRAM

Payment to transitional living program that requires a level of on site supervision.

0290 – INSTITUTION GROUP HOME/ADVANCE PAYMENT

Advance payment to institutions and group homes with reconciliations to cost, as negotiated by contract.

0291 – CONTRACTED OVER 21 PLACEMENT COSTS

Non-Medicaid Contracted Placement Costs for youth over 21 years of age. This requires Director's Office approval.

0292 – NON CONTRACTED OVER 21 PLACEMENT COSTS

Payments for non-Medicaid non-contracted placement costs for youth over 21 years of age. This requires Director's Office approval.

0299 – MISCELLANEOUS GROUP HOME & INSTITUTION/NOT CLASSIFIED ELSEWHERE

Payment for Group Home and Institution expenses not included or defined in other services codes.

0301 – ADOPTION SUBSIDY/ONGOING

Payment based on the adoptive family's adjusted gross income, the monthly ongoing adoption assistance payment.

0302 – ADOPTION SUBSIDY/LEGAL

DCFS payment up to a specified maximum per adopted child for nonrecurring adoption expenses. These expenses include reasonable and necessary adoption fees, court costs attorney fees and other attorney and adoptive family expenses directly related to the legal adoption of a child with special needs.

0303 – ADOPTION SUBSIDY/MEDICAL

One time only or continuous payment may be made for any child receiving ongoing monthly payments who need medical services related to conditions which existed prior to the child's adoption which are not covered by the adopting family's medical insurance, by the Division of Specialized Care for Children or DPA.

0304 – ADOPTION SUBSIDY/HEALTH INSURANCE

0305 – ADOPTION CONTRACTS/STANDARD PROGRAM

Payment for contracts entered into with licensed child welfare agencies only. The standardized program plan and payment provisions must be attached to the contract.

0306 – ADOPTION CONTRACTS/NON-STANDARD PROGRAM

Payments for contracts entered into with licensed child welfare agencies only. The program plan and payment provisions must be attached to the contract. The program plan details the minimal contractual requirements, additional stipulations are negotiated.

0307 – SPECIAL SERVICE FEE/ADOPTION ASSISTANCE

Payments for special service fees included in adoption assistance agreements submitted to the family prior to 11/28/95. Transportation related to medical or school needs. Diet related to medical needs. Expenses related to special care based on the physical, mental and emotional problem/handicap of the child.

0308 – COUNSELING – ADOPTION ASSISTANCE

Payment for counseling services not covered by the family's insurance, another state agency, or any other financial resource, provided the counseling is related to the child's documented preexisting condition.

0310 – ADOPTION/OTHER SPECIAL SERVICES

Payment for day care that provides therapeutic intervention. Day care must include treatment of a disability or a disease as an integral part of the programming. Examples include speech, physical or occupational therapy, behavior modification, psychological or psychiatric services.

0312 – ADOPTION LISTING SERVICES

Payment for listing the child with the Adoption Listing Service and any follow-up inquiries on the listing.

0313 – ADOPTION SUBSIDY – STANDARD AGE RATE

Payments for adoption subsidy for agreements submitted to family prior to 11/28/95 computed at the standard rate.

0317 - ADOPTION SUBSIDY (POST 9/30/08) – STANDARD RATE

Subsidy payments for child who resided in placements receiving regular foster care board rate and the adoption was finalized after 9/30/08.

0318 - ADOPTION SUBSIDY NON-WARD (POST 9/30/08) – STANDARD RATE

Subsidy payments for child who was not a ward of the state receiving regular foster care board rate and the adoption was finalized after 9/30/08.

0322 – SACY POST-ADOPTION/POST-3G

Payments for counseling for SACY clients in post adoption and post subsidized guardianship programs.

0331 – ADOPTION SUBSIDY (PRIOR TO 7/1/95) – STANDARD RATE – NO 7/1/06 COLA

Subsidy payments for child who resided in placements receiving regular foster care board rate prior to 7/1/06 and is not eligible for other benefits (SSA, SSI, etc); adoption assistance cases for which the adoption assistance agreement was submitted to the family prior to 7/1/95.

0332 – ADOPTION SUBSIDY (POST 6/30/95) – STANDARD RATE – NO 7/1/06 COLA

Subsidy payments for child who resided in placements receiving the regular foster care board rate prior to 7/01/06, and is not eligible for other benefits (SSA, SSI, etc); adoption assistance cases for which the adoption assistance agreement was submitted to the family after 6/30/95.

0333 – ADOPTION SUBSIDY (PRIOR TO 7/1/95) – INTENSIVE RATE

Subsidy payments for child who resided in a foster family home receiving the intensive board rate or resided in a group home, institution or other residential placement and is not eligible for other benefits, adoption assistance cases for which the adoption assistance agreement was submitted to the family prior to 7/1/95.

0334 – ADOPTION SUBSIDY (POST 6/30/95) – INTENSIVE RATE

Subsidy payments for child who resided in a foster family home receiving the intensive board rate or resided in a group home, institution or other residential placement and is not eligible for other benefits, adoption assistance cases for which the adoption assistance agreement was submitted to the family after 6/30/95.

0336 – ADOPTION SUBSIDY – SPECIAL RATE/MANUALLY ENTERED

Subsidy payments for a child who resided in specialized foster care prior to adoption.

0338 – ADOPTION SUBSIDY – NO COLA

Subsidy payments for any adoption assistance case where the adoptive parents have indicated they do not want cost of living increases or adjustments based on the child's age. Rate entered manually by the Region.

0339 – ADOPTION SUBSIDY NON-WARD (PRIOR TO 7/1/06) – STANDARD RATE – NO 7/1/06 COLA

Subsidy payments for child who is not a ward of the state receiving the regular foster care board rate and is not eligible for other benefits (SSA, SSI, etc); adoption assistance cases for which the adoption was finalized prior to 7/1/06.

0346 – ADOPTION SUBSIDY (POST 6/30/06) – STANDARD RATE

Subsidy payments for child who resided in placements receiving regular foster care board rate and is not eligible for other benefits (SSA, SSI, etc); adoption assistance cases for which the adoption was finalized after 6/30/06.

0347 – ADOPTION SUBSIDY NON-WARD (POST 6/30/06) – STANDARD RATE

Subsidy payments for child who is not a ward of the state receiving the regular foster care board rate and is not eligible for other benefits (SSA, SSI, etc); adoption assistance cases for which the adoption was finalized after 6/30/06.

0349 – ADOPTION SUBSIDY – SPECIAL RATE – NON-WARD

Subsidy payments for a child who is not a ward of the state receiving a specialized foster care subsidy.

0350 – ADOPTION SUBSIDY UNDER 19 IN SCHOOL

Subsidy payment for any adoption assistance case where the child is age 18 and still in school, proof of which is in the case file.

0351 – ADOPTION SUBSIDY UNDER 19 IN SCHOOL, NON-WARD

Subsidy payment for any non-ward adoption assistance case where the child is age 18 and still in high school, proof of which is in the case file.

0352 – ADOPTION SUBSIDY UNDER 21 WITH/DISABILITY, NON-WARD

Subsidy payment for any non-ward adoption assistance case where the child is between age 18 and 21 and is disabled, proof of which is in the case file.

0355 – ADOPTION SUBSIDY UNDER 21 WITH/DISABILITY

Subsidy payment for any adoption assistance case where the child is between age 18 and 21 and is disabled, proof of which is in the case file.

0356 – POST ADOPTION/PSYCHOLOGICAL EVALUATIONS

0357 – POST GUARDIANSHIP/PSYCHOLOGICAL EVALUATIONS

0361 – AA/SG DAYCARE – LICENSED DAY CARE CENTER

Employment related day care payments for adoptive families and subsidized guardians with children under 3 years of age for Licensed Day Care Centers effective 7/1/01.

0362 – AA/SG DAYCARE – LICENSED EXEMPT CENTER

Employment related day care payment for adoptive families and subsidized guardians with children under 3 years of age for Licensed Exempt Centers effective 7/1/01.

0363 – AA/SG DAYCARE – LICENSED DAY CARE HOME

Employment related day care payment for adoptive families and subsidized guardians with children under 3 years of age for Licensed Day Care Home effective 7/1/01.

0364 – AA/SG DAYCARE – LICENSED EXEMPT HOME

Employment related day care payment for adoptive families and subsidized guardians with children under 3 years of age for Licensed Exempt Homes effective 7/1/01.

0366 – AA/SG DAYCARE – TRADITIONAL CHILDS HOME

Employment related day care payment for adoptive families and subsidized guardians with children under 3 years of age for Traditional Childs Homes effective 7/1/01.

0367 – AA/SG DAYCARE – RELATIVE RELATIVES HOME

Employment related day care payment for adoptive families and subsidized guardians with children under 3 years of age for Relative Relatives Homes effective 7/1/01.

0368 – AA/SG DAYCARE – RELATIVE CHILDS HOME
Employment related day care payment for adoptive families and subsidized guardians with children under 3 years of age for Relative Childs Homes effective 7/1/01.

0369 – AA/SG DAYCARE – LICENSED GROUP DAY CARE HOME

Employment related day care payment for adoptive families and subsidized guardians with children under 3 years of age for Licensed Group Day Care Homes effective 7/1/01.

0370 – SUBS GUARDIAN SUBSIDY UNDER 19 IN SCHOOL

Subsidy payment for any adoption assistance case where the child is age 18 and is still in school, proof in the case file. The rate will mirror that prior to the child turning age 18 and must be manually entered.

0373 – SUBSIDIZED GUARDIAN SUBSIDY (POST 6/30/06) – RELATIVE – STANDARD

Payments applicable to the Subsidized Guardianship program for subsidy paid to a relative guardian where guardianship was granted after 6/30/06.

0374 – SUBSIDIZED GUARDIAN SUBSIDY (POST 6/30/06) – STANDARD RATE

Payments applicable to the Subsidized Guardianship program for subsidy paid to a traditional guardian where guardianship was granted after 6/30/06.

0375 – SUB GUARDIAN SUBSIDY UNDER 21 WITH DISABILITY

Subsidy payment for any adoption assistance case where the child is between age 18 and 21 and is disabled, proof in the case file. The rate will mirror that prior to the child turning age 18 and must be manually entered.

0376 – SUBSIDIZED GUARDIAN SUBSIDY (POST 9/30/08) – RELATIVE – STANDARD

Payments applicable to the Subsidized Guardianship program for subsidy paid to a relative guardian where guardianship was granted after 9/30/08.

0377 – SUBSIDIZED GUARDIAN SUBSIDY (POST 9/30/08) – STANDARD RATE

Payments applicable to the Subsidized Guardianship program for subsidy paid to a traditional guardian where guardianship was granted after 9/30/08.

0380 – ADOPTION COMPANION CONTRACT

0385 – OUT OF HOME-FINANCIAL SUPPORT/SG

0389 – AA/SG INCENTIVE GRANT

Independence Facilitation Grant payments in accordance with Policy Guide 2001.14. This is a grant payable to the eligible youth upon termination of an adoption assistance or guardianship subsidy.

0394 – ADOPTION/TRANSPORTATION COST

0399 – MISCELLANEOUS ADOPTION/NOT ELSEWHERE CLASSIFIED

Payment for adoption expenses not included or defined in other service codes.

0401 – AGENCY COUNSELING

Payment for counseling services purchased from an agency.

0402 – INDIVIDUAL COUNSELING SERVICES AND EXPENSES

Payment for counseling purchased from an individual.

0403 – AGENCY ADVOCACY

Payment for advocacy services purchased from an agency.

0404 – INDIVIDUAL ADVOCACY SERVICES AND EXPENSES

Payment of the negotiated hourly rate for the actual hours on assignment. 40 hours per week unless special contract approval of Director. Does not include supplies, meals, or activities outside the realm of the contract.

0407 – NON MEDICAID COUNSELING

0408 – AGENCY COUNSELING/PROJECT SAFE SERVICE

Payment for counseling services purchased from an agency for clients in Project Safe Program.

0409 – AGENCY – FAMILY EDUCATION SERVICES

Payment for agency family parenting service through classroom or small group education or behavioral training and feedback in the home.

0410 – INDIVIDUAL –FAMILY EDUCATION SERVICES

Payment for individual family parenting service through classroom or small group education or behavioral training and feedback in the home.

0411 – INTERPRETER SERVICES FOR HEARING IMPAIRED

Payment for sign language interpreters for hearing impaired clients. Also used to enable hearing impaired clients to receive other services such as counseling, homemaker, etc.

0412 – INTERPRETER SERVICES FOR LIMIT/NON ENGLISH

Payment for foreign language interpreters for limited/non-English speaking clients if a staff person who speaks the client's primary language is not available. Also used to enable clients to receive other services such as counseling, homemaker, etc.

0414 – SACY/CLINICAL ASSESSMENTS

Payments for clinical assessments of the SACY (Sexually Abusive Children and Youth) Program

0415 – CONSULTATION SERVICES/MENTAL HEALTH

Payment for counseling services for clients with special mental health issues.

0416 – CONSULTATION SERVICES/SUBSTANCE ABUSE

Payment for counseling services for clients with substance abuse issues.

0418 – CONSULTATION SERVICES/SEXUAL ABUSE

Payment for counseling services for clients with sexual abuse issues.

0419 – CONSULTATION SERVICES/MISCELLANEOUS

Payment for miscellaneous counseling expenses for clients.

0421 – GRANTS TO CHILDREN'S ADVOCACY CENTER

Supplemental support payments to assist Children's Advocacy Centers. Child Advocacy Centers are county-based programs, which coordinate the investigation of child abuse reports by the Department, law enforcement agencies, the State's Attorney's Office, local medical and mental health associations.

0422 – SACY OUTPATIENT

Payment for counseling and other behavioral training offered by qualified agencies.

0423 – COUNSELING/LANS

Payment for counseling services offered to families or individuals by Local Area Networks.

0425 – TOXICOLOGY TESTING

Payment for toxicology testing such as urinalysis, blood, etc.

0426 – INTACT COUNSELING

Payment for counseling services for clients with issues concerning keeping the family together.

0427 – PROJECT SAFE GRADUATION PAYMENT

Payment for maximum $240 graduation fee for client who completes Project SAFE graduation, which includes the successful completion of intensive out-patient treatment, parenting training program, aftercare services and involvement in an AA/NA or women's support network.

0430 – SUBSIDIZED GUARDIAN/COUNSELING

Payment for counseling services authorized on a case-by-case basis when unusual or unexpected circumstances arise that may impair the guardian's ability to maintain the permanency goal.

0441 – PSYCHOLOGICAL EVALUATIONS AGE 0-5

Payment for psychological evaluations performed by Illinois licensed psychologists approved by DCFS for the purpose of case planning.

0442 – PSYCHOLOGICAL EVALUATIONS AGE 6 - ADULT

Payment for psychological evaluations performed by Illinois licensed psychologists approved by DCFS for the purpose of case planning.

0443 – PSYCHOLOGICAL EVALUATIONS AGE 12-17 (NO LONGER USED)

Payment for psychological evaluations performed by Illinois licensed psychologists approved by DCFS for the purpose of case planning.

0444 – PSYCHOLOGICAL EVALUATIONS AGE 18 – ADULT (NO LONGER USED)

Payment for psychological evaluations performed by Illinois licensed psychologists approved by DCFS for the purpose of case planning.

0445 – PSYCHOLOGICAL EVALUATIONS HOME BASED ASSESSMENT

Payment for psychological evaluations performed by Illinois licensed psychologists approved by DCFS for the purpose of case planning.

0446 – OTHER PSYCHOLOGICAL EVALUATIONS COST

Payment for psychological evaluations performed by Illinois licensed psychologists approved by DCFS for the purpose of case planning.

0447 – PSYCHOLOGICAL EVALUATIONS BONDING ISSUES

Payment for bonding assessment psychological evaluations performed by an Illinois licensed psychologist approved by DCFS for the purpose of case planning.

0448 - ALLOWANCE FOR COURT TESTIMONY (CREDENTIALED PSYCHOLOGIST)

Payment for court testimony including time for preparation, travel, waiting and actual testimony. Payment only for the licensed psychologist who signed the evaluation report and attends the court hearing.

0451 – FOCUSED NEUROPSYCHOLOGICAL EVALUATION

Payment for focused neuropsychological evaluations performed by an Illinois licensed psychologist approved by DCFS for the purpose of case planning.

0452 – COMPREHENSIVE NEUROPSYCHOLOGICAL EVALUATION

Payment for comprehensive neuropsychological evaluations by an Illinois licensed psychologist approved by DCFS for the purpose of case planning.

0453 – PARENTING CAPACITY ASSESSMENT FEE

Payment for the parenting capacity assessment. This fee includes as many as two caregivers and two children from a single household and travel time to and from the client's residence.

0490 – COUNSELING/ADVANCE PAYMENT

Advance payment for counseling services as specified by contract.

0491 – COUNSELING/ADVOCACY/MENTORING GRANTS

Payments for miscellaneous counseling, advocacy, and/or mentoring services not classified elsewhere. Payments are on a grant basis rather than a fee-for-service basis.

0492 – FAMILY EDUCATOR TRAINING

Payments to Individual Family Preservation Family Educators of their hourly rate while in training. It does not require a case ID.

0501 – AGENCY HOMEMAKER

Payment for emergency caretaker or homemaker services purchased from an agency in accordance with a negotiated contract.

0505 – FAMILY HABILITATION TRAINING

Payment for Family Habilitation training at negotiated hourly rates for actual hours of work or at reasonable prices per deliverable. A program plan shall detail the services to be provided, the target group receiving the services, the means to evaluate the success of the training and the method of payment.

0507 – AGENCY FAMILY HABILITATION SERVICES

Family Habilitation services to promote permanency by maintaining, strengthening and safeguarding the functioning of families to prevent substitute care placements, promote family reunification, stabilize foster care placements and facilitate youth development. This program will be distinct and separate from any other homemaker services provided to other state agencies. It was developed to define the higher level of services.

0606 – PROTECTIVE/FAMILY MAINTENANCE DC CENTER

Payment for day care for children living in their own homes by DCFS when the service is identified as necessary to protect the children or to maintain an intact family or for reunification.

0607 – PROTECTIVE/FAMILY MAINTENANCE DC HOME – LICENSED

Payment for day care for children living in their own homes by DCFS when the service is identified as necessary to protect the children or to maintain an intact family or for reunification.

0608 – PROTECTIVE/FAMILY MAINTENANCE DC HOME – UNLICENSED

Payment for day care for children living in their own homes by DCFS when the service is identified as necessary to protect the children or to maintain an intact family or for reunification.

0609 – PROTECTIVE/FAMILY MAINTENANCE DC BABYSITTER

Payment for day care for children living in their own homes by DCFS when the service is identified as necessary to protect the children or to maintain an intact family or for reunification.

0610 – PROTECTIVE/FAMILY MAINTENANCE DC RELATIVE-RELATIVE HOME

Payment for day care for children living in their own homes by DCFS when the service is identified as necessary to protect the children or to maintain an intact family or for reunification.

0615 – THERAPEUTIC FAMILY DAY CARE

Payment for therapeutic day care to children who are at risk of placement in order to keep the family intact. Includes treatment of a child's physical, mental or emotional disability as an integral part of the programming. Includes speech, physical or occupational therapy, behavior modification, psychological or psychiatric services to include periodic developmental testing.

0616 – SITE ADMINISTERED DAY CARE AGENCY

0620 – FWF TRAINING/DEVELOPMENT

Payment for Families with a Future training and development services.

0632 – PROTECTIVE/FAMILY MAINTENANCE RELATIVE IN CHILD'S HOME

Payment for day care for children living in their own homes by DCFS when the service is identified as necessary to protect the children or to maintain an intact family or for reunification.

0633 – PROTECTIVE/FAMILY MAINTENANCE LICENSED EXEMPT CENTER

Payment for day care for children living in their own homes by DCFS when the service is identified as necessary to protect the children or to maintain an intact family or for reunification.

0634 – PROTECTIVE/FAMILY MAINTENANCE LICENSED FAMILY GROUP HOME

Payments for day care to licensed group home for at risk DCFS children.

0639 – PROJECT SAFE – DAY CARE

Payment for day care services for children whose mothers were participating in Project SAFE programs or other Department sanctioned drug treatment programs, which are intensive outpatient alcohol/substance abuse treatment programs, and who are receiving other services from the Department.

0640 – PROJECT SAFE – DAY CARE EXPENSES

Payment for day care services for children whose mothers were participating in Project SAFE programs or other Department sanctioned drug treatment programs, which are intensive outpatient alcohol/substance abuse treatment programs, and who are receiving other services from the Department.

0641 – RESOURCE AND REFERRAL/CORE SERVICES

Payment for day care for Department wards in Department or private agency foster care, if required due to employment or training leading to employment of the foster parents or relative caretakers or for other documented and necessary reasons.

0663 – LICENSED DAY CARE CENTER – DAY CARE

Payment for day care for Department wards in Department or private agency foster care, if required due to employment or training leading to employment of foster parents or relative caretakers or for other documented and necessary reasons.

0664 – LICENSED EXEMPT DAY CARE CENTER – DAY CARE/FOSTER CARE

Payments to license exempt center for day care services as needed for employment of the foster parents.

0665 – LICENSED DAY CARE HOME – DAY CARE/FOSTER CARE

Payments to licensed day care center as needed for employment of the foster parents.

0666 – LICENSED EXEMPT DAY CARE HOME – DAY CARE/FOSTER CARE

Payment for day care for Department wards in Department or private agency foster care, if required due to employment or training leading to employment of the foster parents or relative caretakers or for other documented and necessary reasons.

0667 – BABYSITTER – DAY CARE/FOSTER CARE

Payment for day care for Department wards in Department or private agency foster care, if required due to employment or training leading to employment of the foster parents or relative caretakers or for other documented and necessary reasons.

0668 – RELATIVE HOME – DAY CARE/FOSTER CARE

Payment for day care for Department wards in Department or private agency foster care, if required due to employment or training leading to employment of the foster parents or relative caretaker or for other documented and necessary reasons.

0669 – LICENSED GROUP DAY CARE HOME – DAY CARE/FOSTER CARE

Payment for day care for Department wards in Department or private agency foster care, if required due to employment or training leading to employment of the foster parents or relative caretakers or for other documented and necessary reasons.

0670 – DAY CARE AGENCY – DAY CARE/FOSTER CARE
Payment for day care for Department wards in Department or private agency foster care, if required due to employment or training leading to employment of the foster parents or relative caretakers or for other documented and necessary reasons.

0671 – RELATIVE/CHILDS HOME – DAY CARE/FOSTER CARE

Payment for day care for Department wards in Department or private agency foster care, if required due to employment or training leading to employment of the foster parents or relative caretakers or for other documented and necessary reasons.

0680 – FWF – DAY CARE HOME – LICENSED

Payment for day care service for high risk or at-risk infants between the ages of 0 to 12 months and their preschool siblings.

0685 – FWF – DAY CARE AGENCY

Payment for day care services for high risk or at-risk infants between the ages of 0 to 12 months and their preschool siblings.

0688 – FAMILY HOME NETWORK/FOSTER CARE DAY CARE

Payment for day care for Department wards in Department or private agency foster care, if required due to employment or training leading to employment of the foster parents or relative caretakers or for other documented and necessary reasons.

0689 – DAY CARE REGISTRATION FEE

Payment of up to a specified max per child, per year, for Registration/Admission to a day care center, if required.

0701 – YOUTH IN EMPLOYMENT – GRANTS (NO NEW CLIENTS AFTER 12/31/05)

Payment to adolescents 17 through 20 years of age who are admitted into the Youth in Employment Program.

0702 – EMPLOYMENT INCENTIVE PROGRAM – INITIAL EXPENSES

Payment for initial expenses related to employment.

0706 – YOUTH IN TRANSITION/GRANTS/CUS

0708 – EMPLOYEE INCENTIVE PROGRAM / GRANTS – Effective 01/01/06

Payment to adolescents 17 through 20 years of age who are admitted into the Employment Incentive Program.

0710 – EDUCATIONAL AND TRAINING VOUCHERS

Non-board vouchered reimbursement of education and training costs using Chaffee ILO funds (new in FY04 (FFY03) for wards and former wards 18-22.99 years old. Can only be used by Central Office, within the specified annual maximum.

0720 – YOUTH IN COLLEGE/VOCATIONAL TRAINING PROGRAM/GRANTS

Payment for supplemental services and cash maintenance to youth for whom the Department is legally responsible and who are enrolled full time in college or other post high school educational programs.

0721 – YOUTH IN COLLEGE/VOCATIONAL TRAINING PROGRAM – INITIAL EXPENSES

One-time payment made to youth in the YIC program to cover initial expenses associated with them beginning college.

0725 – YOUTH IN COLLEGE/GRANTS

0730 – SELF SELECTED PLACEMENTS-INDEPENDENT LIVING

A standard of need type payment that will be paid directly to the youth who has selected their own placement. The caseworker has determined it is a safe environment and the youth is between18 and 21 years of age.. It can only be entered by the Central Payment Unit.

0801 – DEPARTMENT SCHOLARSHIP LIVING EXPENSES

Payments for scholarship youth receive a grant per month for room and board while attending college or university.

0802 – DEPARTMENT SCHOLARSHIP ONE TIME ONLY INITIAL EXPENSES

An initial one-time only payment is authorized for expenses/supplies necessary to establish independence when youth becomes own payee.

0806 – DEPARTMENT SCHOLARSHIP LIVING EXPENSES

Payment for scholarship youth who receive a grant per month for room and board while attending college or university. Used by Central Office to direct payment from another appropriation.

0909 – FOSTER CARE EXEMPT

A unique foster care program that may pay a non-standard rate, but is not classified as specialized foster care and does not follow the normal specialized foster care protocols.

0999 – MISCELLANEOUS UNMARRIED MOTHERS/NOT ELSEWHERE CLASSIFIED

Payment for unmarried mother expenses not included in Maternity Home Care services.

1001 – PSYCHOLOGICAL AND PSYCHIATRIC EVALUATIONS AND CONSULTATIONS

Payments for family psychiatric evaluations are available when a diagnostic evaluation is necessary to assist in developing a plan for the child's family.

1003 – INPATIENT PSYCHIATRIC HOSPITAL

Payment for psychiatric hospitalization services for non-wards for whom DHFS is not responsible; payment for psychiatric hospitalization services beyond medical necessity as determined by DHFS.

1101--MEDICAL EXPENSES RELATED TO ABUSE AND NEGLECT INVESTIGATION

Payment for children for whom the Department is providing medical services related to abuse and neglect investigations when payment is not made through Medicaid.

1103 – UNWED MOTHERS MEDICAL EXPENSES

Payment for children for whom the Department is providing medical services related to unwed mothers when payment is not made through Medicaid.

1104 – IN-PATIENT HOSPITAL SERVICES

Payment for children for whom the Department is providing in-patient hospital services when payment is not made through Medicaid.

1105 – OUT-PATIENT HOSPITAL SERVICES

Payment for children for whom the Department is providing outpatient hospital services when payment is not made through Medicaid.

1106 – CLINIC SERVICES

Payment for children for whom the Department is providing clinic services when payment is not made through Medicaid.

1107 – PHYSICIANS SERVICES

Payment for the pre-admission physical examination for children for whom the Department is providing services when payment is not made through Medicaid. For children through age 12 or up to age 21 for children who are seriously handicapped or developmentally disabled.

1108 – OPTICAL/EYEGLASSES

Payment for children for whom the Department is providing eyeglasses when payment is not made through Medicaid.

1109 – OTHER OPTICAL SERVICES

Payment for children for whom the Department is providing other optical services when payment is not made through Medicaid.

1110 – DENTAL/ORTHODONTIC SERVICES

Payment for children for whom the Department is providing orthodontic services when payment is not made through Medicaid.

1111 – OTHER DENTAL SERVICES

Payment for children for whom the Department is providing other dental services when payment is not made through Medicaid.

1112 – PODIATRY SERVICES

Payment for children for whom the Department is providing podiatry services when payment is not made through Medicaid.

1114 – INDEPENDENT LABORATORY SERVICES

Payment for children for whom the Department is providing independent laboratory services when payment is not made through Medicaid.

1115 – DRUGS

Payment for children for whom the Department is providing prescribed drugs when payment is not made through Medicaid.

1116 – MEDICAL SUPPLIES AND EQUIPMENT

Payment for children for whom the Department is providing medical supplies and equipment when payment is not made through Medicaid.

1119 – AUDIOLOGICAL SERVICES

Payment for children for whom the Department is providing audiological services when payment is not made through Medicaid.

1120 – THERAPY SERVICES

Payment for children for whom the Department is providing therapy services when payment is not made through Medicaid.

1121 – NURSING SERVICES

Payment for children for whom the Department is providing nursing services when payment is not made through Medicaid.

1123 – HMR LICENSING MEDICAL EXAM REIMBURSEMENT

Reimbursement of required medical exams for all family members in a household providing relative foster care services, attempting to become licensed.

1201 – INITIAL PLACEMENT CLOTHING/PERSONAL HYGIENE EXPENSES

Payment for one-time only clothing expenses to be authorized for a child in his first out-of-home placement at the time the case is opened or within 6 months. Also includes personal hygiene needs, for example, toothbrush, toothpaste, hairbrush, comb, deodorant, etc.

1202 – REPLACEMENT CLOTHING

Payment for replacement clothing costs include those due to destruction of clothing by fire, flood or child's willful destruction; because of unsuitability of clothing due to health or medical reasons.

1203 – CAMP CLOTHING FOR WARDS/REQUIRED

Payment for required items for camp documented in the form of a written recommendation from the camp.

1204 – CAMP CLOTHING FOR NON-WARDS/REQUIRED

Payment for clothing needed for camp, which must be documented by written recommendation from the camp. Purchase authorizations must be accompanied by camp's list of required items. Only items required by the camp can be purchases.

1205 – UNWED MOTHERS CLOTHING – WARDS

Clothing vouchers issued to unwed mothers for maternity clothes for DCFS children.

1301 – BOOK AND SCHOOL FEES

Payment for books and school supplies if school district waiver policy does not include summer school fees and the district refuses to pay, the Department will pay the cost.

1302 – GRADUATION EXPENSES

Payment for junior and senior year high school children for all graduation items including pictures, yearbook, cap and gown rental, class ring, new clothing for graduation and other related fees.

1303 – TUITION

Payment for tuition for trade school.

1304 – TUTORING

Payment for tutoring provided for wards in situation including if the child is behind in grade levels/achievements, has one or more failing grades, tutoring recommended by the school, has been retained one or more years, has received one or more class/subject deficiency reports.

1305 – SCHOOL TRIPS

Payment for school trips with recommendation from school to be kept in the case file.

1306 – SUMMER SCHOOL SUPPLIES

Payment for summer school supplies such as pens, paper, notebooks, etc.

1307 – REGULAR SCHOOL SUPPLIES

Payment for school supplies for any placement after July 31 in which a child has not received school supplies payment from CPPM. Supplies include pens, pencils, notepaper, notebooks, calculators, pocket dictionaries, crayons, glue, erasers, rulers, etc.

1308 – ATHLETIC INSURANCE

Payment for athletic insurance purchased if required by school for athletic participation only.

1309 – REQUIRED GYM/ATHLETIC EQUIPMENT

Payment for items required to participate in school gym classes.

1310 – BOARD PAYMENT SCHOOL SUPPLIES

An automatic payment in August based on child's July 31 placement, via the board system for Department supervised school-age children in foster homes.

1311 – POST-SECONDARY PREPARATIONS FEES

Payments for wards in high school for fees related to preparing for college. Such fees include ACT/SAT test and college/vocational school application fees.

1315 – FOSTER HOME INFANT CARE EQUIPMENT

Payment to a foster or relative home for infant care equipment for a specific child age 2 and under.

1401 – SCHOOL TRANSPORTATION

Payment if child's placement address is outside the school district boundaries, the school district does not or cannot provide transportation, or the school district does not reimburse foster parent for school transportation. Includes school transportation for disabled children or for children attending special schools.

1402 – MEDICAL TRANSPORTATION

Payment for transportation for medical reasons.

1403 – DAY CARE TRANSPORTATION

Payment for transportation to a day care center provider for children receiving Protective/Family Maintenance Day Care or Foster Care Day Care. Provided for children through age 12 or to age 21 for children who are seriously handicapped or developmentally disabled.

1404 – CAMP TRANSPORTATION FOR WARDS

Payment for transportation expenditures for transportation to and from camp only.

1405 – CAMP TRANSPORTATION FOR NON-WARDS

Payment to the provider of services only. Transportation expenditure is allowable only for transportation to and from camp.

1406 – MENTAL HEALTH RELATED TRANSPORTATION

Payment for transportation for mental health related reasons.

1407 – PARENTAL VISITS – CHILD TRAVEL EXPENSE

Payment to transport child/children for parental visits if all other resources have been exhausted when the plan for the child is to return home. (Effective 11/1/07, this code is no longer used for the cost of transporting the parent/s to the visit)

1408 – PROSPECTIVE ADOPTIVE PARENTS

Payment for transporting a child for the purpose of prospective adoption.

1410 – RETURN TO RUNAWAY FOR WARDS

Payment for expenses related to return of child for whom DCFS is legally responsible. Travel should be most economical and reasonable mode available.

1411 – RETURN OF RUNAWAY FOR NON-WARDS

Payment for expenses related to return of a non-ward. Travel should be most economical and reasonable mode available.

1412 – TRANSPORTATION TO PROSPECTIVE PLACEMENTS

Payment for cost of transporting a child for the purpose of placement. Travel by the most economical and reasonable mode available.

1413 – TRANSPORTATION – CASE REVIEW

Payment for parents and/or children to attend an Administrative Case Review if all other resources have been exhausted.

1414 – TRANSPORTATION NOT ELSEWHERE CLASSIFIED

Payment for transportation expenses not included or detailed in other service codes.

1501 – ART, DANCING, MUSIC AND ATHLETIC LESSONS

Payment to include, but not limited to, art, acting, dancing, music, athletic instruction, made at the prevailing community rate.

1502 – MUSICAL INSTRUMENT RENTAL

Payment for musical instrument rental at the prevailing community rental rate including reasonable insurance charges at current market rate for musical instrument rental.

1503 – MUSICAL INSTRUMENT PURCHASE

Payment for musical instrument purchase. A used instrument shall be considered prior to purchasing a new one. Purchase considered only for a child demonstrating an interest for the instrument for at least 6 months. Instrument becomes property of the child.

1504 – MEMBERSHIP FEES AND RELATED EQUIPMENT

Payment items include Boy Scouts, Girl Scouts, 4-H, YMCA and other similar groups. Also covers costs of swimming passes and required supplies. Paid at prevailing rate.

1505 – CAMP FEES – WARDS

Payment for camp fees authorized for children in placement when such is seen as essential for the child's social development. Includes day camp.

1506 – CAMP FEES – NON-WARDS

Payment for camp fees authorized for children receiving social services in their own homes when such is seen as essential for the child's social development. Includes day camp.

1507 – CAMP SUPPLIES – WARDS

Payment for camp supplies authorized for activities not included in camp fee.

1508 – CAMP SUPPLIES – NON-WARDS

Payment for camp supplies for activities not included in camp fee.

1509 – SUPERVISED OVERNIGHT CAMPING – WARDS

Payment for an overnight summer camping experience to Department wards age 7 through 16 including programs involving swimming, camp craft, nature hiking and arts and crafts.

1690 – COURT ORDERED MARRIAGE DISSOLUTION/HOME STUDIES

Payment for home studies, reports and recommendations prepared as specified in the Standard Program Plan. The worker shall initiate procedures to bill the responsible parties (parents) for the service. An open case is not required for families to be eligible for this service.

1691 – INTERSTATE COMPACT HOME STUDIES

Interstate Compact on the Placement of Children is a law enacted by most states for handling the interstate placement of children in foster homes, adoptive homes, or other childcare facilities. Each child placed across state lines must be assured of receiving appropriate care. Home studies are requested to assure that each child is not receiving appropriate care. An open case is not required.

1692 – ADOPTIVE HOME STUDIES

Home studies, reports and recommendations should be prepared to ensure adequate care for adoptive children. The worker shall initiate procedures to bill the responsible parties (adoptive parents) for the service. An open case is not required for families to be eligible for this service.

1693 – COURT ORDERED SUPERVISED VISITATION

Payment for reports in accordance with the terms of the court order for children age 0 thru 17 and their families or guardians. The worker shall initiate procedures to bill the responsible parties (parents) for the service. An open case is not required for families to be eligible for this service.

1901 – LEGAL FEES

1902 – BIRTH CERTIFICATES

Payment to obtain copies of birth certificates when required.

1903 – FUNERAL AND BURIAL EXPENSES

Payment to obtain copies of death certificates when required.

1904 – OTHER MISCELLANEOUS

Miscellaneous expenses not included or defined in other service codes.

1905 – GUARDIAN SUCCESSOR/LEGAL

Payment for legal fees if the transfer is not completed but an agreement had been entered in advance.

1908 – IRCA – LEGALIZATION FEE

1930 – SUBSIDIZED GUARDIAN/LEGAL NON-RECURRING EXPENSES

Payments of one-time court costs and legal fees, if required, in connection with the establishment of guardianship.

2001 – TLS BASIC LIFE SKILLS TRAINING – GROUP

Payment for group or individual instruction for youth in basic life skills purchased from individual trainers or organizations. Payments negotiated at hourly rate per hours of instruction. Expenses and refreshments reimbursed at cost.

2002 – TLS VOCATIONAL TRAINING

Payment for vocational training classes, job coaches, subsidized employment, sheltered workshops, and trade school tuition purchased for eligible youth. Tuition, grant amounts or rates of pay negotiated by contract or established community standards.

2003 – TLS LIFE SKILLS COORDINATOR AGENCY

Payment for life skills instructor services through an agency contract that includes supporting youth to achieve objectives and goals that will enhance the youth's maturity and ability to function as an independent, self-sufficient individual.

2004 – TLS LIFE SKILLS COORDINATOR INDIVIDUAL

Payment for life skills instructor services purchases from an individual. Does not include supplies, meals or activities outside the realm of the contract.

2006 – TLS LIFE SKILLS INSTRUCTOR/COORDINATOR – MEDICAL EXAMINATION

Reimbursement to life skills instructor for required physical examinations, tuberculin skin test and if indicated, chest x-ray and other laboratory tests prescribed by the physician or Department.

2007 – TLS LIFE SKILLS INSTRUCTOR/COORDINATOR – TRAVEL

Reimbursement for cost of travel includes reasonable amounts spent for bus fare or taxi fare, if no bus is available.

2008 – TLS CAREGIVER/CASEWORKER TRAINING

Payments for training and recruitment of foster parents with an individual or agency demonstrating expertise in the field. Registration fees, training sessions and related travel costs, including babysitting for children of DCFS foster parents may be reimbursed with adequate documentation.

2009 – TLS YOUTH ASSESSMENT AND EVALUATION

Payment to private agency for client assessment and evaluations requested by a caseworker.

2010 – TLS COUNSELING – AGENCY

Payment for counseling purchased from an agency in accordance with a negotiated contract with prior approval of the TPL Administrator.

2011 – TLS COUNSELING – INDIVIDUAL

Payment for counseling purchased from an individual in accordance with a negotiated contract with prior approval of the TPL Administrator.

2012 – TLS YOUTH LEARNING INCENTIVE

Payment to youth as an incentive to participate in and complete a basic life skills training course.

2014 – TLS SCHOOL EXPENSES

Payment for school expenses allowable as required and accompanied by statement of need from school. Includes material for wood shop class, industrial art supplies, home economics supplies, lab supplies, etc.

2016 – TLS TUITION

Payment for tuition for eligible youth to attend special classes that would assist them in completing a high school degree or equivalency. Payment based on rates charged by schools or training centers.

2018 – TLS FIELD TRIPS

Payment for field trips accompanied by recommendation from the TPL Administrator.

2023 – TLS YOUTH TRANSPORTATION – OTHER

Payment for transportation expenses paid for a youth to travel for reasons other than employment, recreation, education and visitation only with prior approval of the TLP Administrator, by most economical means.

2027 – TLS YOUTH RETREAT

Payments for youth to travel to attend retreats or youth clubs. Contracts should specify the program to be offered and should include transportation, meals and lodging for the participant.

2032 – TLS CASE MANAGEMENT – INDIVIDUAL

Payment for case management services purchased for individual youth from qualified individuals pursuant to a contract that details the case management services and expenses to be covered as negotiated by contract.

2127 – CASE ASSESSMENT FEE – PERFORMANCE BASED CONTRACTS

Payment for assessment fee when the Department requests or approves an agency request for a special assessment because of an incomplete file or casework record.

2191 – CURRENT FUNDING PAYMENT/PERFORMANCE BASED CONTRACTS

Payment for estimated monthly board payment prepared by the Department's Division of Budget and Finance

2198 – ADMIN LARGE COOK PERFORMANCE

Payment to private agency for administrative costs, based upon the budgeted allocation of cases at a specific rate prepared by the Department's Division of Budget and Finance. Rate based on caseload ratio of 15:1.

2298 – ADMIN LARGE COOK PERFORMANCE

Payment to private agency for administrative costs, based upon the budgeted allocation of cases at a specific rate prepared by the Department's Division of Budget and Finance. Rate based on caseload ratio of 14.25:1.

2401 – PROV AG/EXORDINARY SVS/CHILD AT HOME

Hourly rate payment for ongoing or extraordinary services such as reports, court appearances and services requested by the Department or required by the courts on behalf of children remaining at home.

2602 – PRIVATE AGENCY UNLICENSED TRADITIONAL – PCC CONTRACTS

Monthly support payment paid directly by DCFS to traditional foster homes that are not licensed. Admin cost to private agency.

2640 – PRIVATE AGENCY UNLICENSED RELATIVE - PCC CONTRACTS

Monthly support payment paid directly by DCFS to relative foster homes that are not licensed. Admin cost to private agency.

2902 – PRIVATE AGENCY LICENSED TRADITIONAL – PCC CONTRACTS

Monthly board rate payment to private agency for ward in a licensed traditional foster home.

2940 – PRIVATE AGENCY LICENSED RELATIVE – PCC CONTRACTS

Monthly board rate payment to private agency for ward in a licensed relative foster home.

3000 – FPS ASSESSMENT

Payment for a comprehensive interview of a family referred for family preservation services. Rates specified by contract.

3001 – FPS GRANT PAYMENT

Payment to cover providers' field expenses in the form of an advance grant paid quarterly or monthly based on program capacity by the Contracts Unit.

3002 – FPS COUNSELING/CASEWORK/COLLATERAL/REPORTS

Payment for counseling, casework, collateral and court appearance services delivered by professional staff and professionally prepared reports.

3003 – FPS DAY CARE SERVICES

Reimbursement for Family Preservation day care services.

3004 – FPS HOMEMAKER SERVICES

Payment for homemaker services performed by a caseworker or a paraprofessional related to Family Preservation services.

3005 – FPS CASH ASSISTANCE

Payment for the purpose of maintaining a family intact when the failure to provide assistance would cause a placement of one or more children. Includes rental deposits, utility deposits, cost of moving families, rental payment, utility payment, car repairs, bus fare to work, etc.

3006 – FPS CONTRACTUAL

Payment of a "pass through" of service expenses subcontracted by the provider for client services only and for Central Office payment for trainers, evaluators and consultants of direct client services.

3007 – FPS REIMBURSEMENT TRAINING EXPENSES

Payment for training expenses of provider and staff outside their service area of the contractor. Includes mileage payments or public transportation, lodging and meal or per diem.

3008 – FPS PARENT TRAINING

Payment for parenting training offered as a course to the family.

3011 – FRS GRANT PAYMENT

Payment to cover providers' field expenses in the form of an advance grant paid quarterly or monthly based on program capacity by the Contracts Unit.

3012 – FRS COUNSELING/CASEWORK/COLLATERAL/REPORTS

Payment for counseling, casework, collateral and court appearance services delivered by professional staff and professionally prepared reports.

3014 – FRS HOMEMAKER SERVICES

Payment for homemaker services performed by a caseworker or a paraprofessional related to Family Reunification services.

3015 – FRS-- CASH ASSISTANCE

Payment for the purpose of maintaining a family intact when the failure to provide the assistance would cause a placement of one or more children. Includes rental deposits, utility deposits, cost of moving families, rental payments, utility payments, car repairs, bus fare to work, etc.

3016 – FRS CONTRACTUAL

Payment for a "pass through" of service expenses subcontracted by the provider for client services only and Central Office payment of trainers, evaluators, and consultants of direct client services.

3021 – APS GRANT PAYMENT

Payment for a grant for pilot Adoption Preservation services available to DCFS clients and members of the general public. Also used to issue advance payments for emergency cash assistance to providers under contract.

3033 – CASE MANAGEMENT/REUNIFICATION/AFTERCARE PERFORMANCE BASED CONTRACTS

Payment for reunification casework services fees for children returned home.

3034 – OTHER SERVICES/REUNIFICATION/AFTERCARE PERFORMANCE BASED CONTRACTS

Grant payment for reunification services, other than casework, based upon a detailed budget.

3041 – FAMILY SUPPORT THERAPY /PARENTING TRAIN

Payment for agency or individual family support therapy or parenting service through classroom or small group education or behavioral training and feedback in the home.

3042 – FAMILY MAINTENANCE INDIVIDUAL COUNSELING SERVICES AND EXPENSES

Payment for reduced intensity counseling services following intensive family preservation.

3043 – FAMILY MAINTENANCE – AGENCY ADVOCACY

Payment for paraprofessional services designed to assist the family or child, to continue and maintain the gains achieved through intensive family preservation services.

3051 – FAMILY MAINTENANCE – AGENCY HOMEMAKER

Payment for paraprofessional homemaker services and/or family habilitation services designed to assist the family or child, to continue and maintain the gains achieved through intensive family preservation services.

3102 – FAMILY PRESERVATION/SUPPORT CONSULTING/RESEARCH

Payments for consultation to the Department and/or research activities performed regarding family preservation. The Department is the client for and recipient of, the research. Payment method is negotiated by contract.

3602 – PRIVATE AGENCY UNLICENSED TRADITIONAL – PCS CONTRACT

Monthly support payment paid directly by DCFS to traditional foster homes that are not licensed. Admin cost to private agency.

3640 – PRIVATE AGENCY UNLICENSED RELATIVE - PCS CONTRACT

Monthly support payment paid directly by DCFS to relative foster homes that are not licensed. Admin cost to private agency.

4001 – ADVANCE TO CASH ASSISTANCE PROVIDER – NORMAN CLASS

Cash assistance for clients in Norman class program.

4002 – SHELTER/SECURITY DEPOSIT/NORMAN CLASS

Security deposit payment to vendor for shelter for clients in Norman class program.

4003 – SHELTER – FIRST MONTHS RENT/NORMAN CLASS

First month’s rent payment to vendor for clients in Norman class program.

4004 – SHELTER – ADDITIONAL RENT PAYMENT/NORMAN CLASS

Additional rent payments to vendor for clients in Norman class program.

4005 – SHELTER – REPAIRS/NORMAN CLASS

Repair payments to vendor for shelter for clients in Norman class program.

4006 – UTILITIES – PREVIOUS/NORMAN CLASS

Utilities payments to vendor for clients in Norman class program.

4007 – UTILITIES – INITIAL COSTS/NORMAN CLASS

Utilities initial cost payments to vendor for clients in Norman class program.

4008 – FOOD/NORMAN CLASS

Payments to vendor for food for clients in Norman class program.

4009 – ADMINISTRATION FEE/NORMAN CLASS

Administrative costs associated with the Norman class program.

4010 – HOUSING ADVOCACY/NORMAN CLASS

Housing advocacy costs associated with the Norman class program.

4011 – CLOTHING/NORMAN CLASS

Payments to vendor for clothing for clients in Norman class program.

4012 – BEDS FOR CHILDREN

Payment to vendor to provide beds for children who are clients in Norman class program.

4013 – TRANSPORTATION/NORMAN CLASS

Transportation costs for clients in Norman class program.

4014 – MISCELLANEOUS/NORMAN CLASS

Miscellaneous costs for clients in Norman class program.

4015 – KITCHEN APPLIANCES

Payment to vendor to provide kitchen appliances for families who are clients in Norman class program.

4016 – FURNITURE OTHER THAN BEDS

Payment to vendor to provide furniture for families who are clients in Norman class program.

4017 – MAJOR CLEANING/EXTERMINATION

Payment to vendor to provide for extermination or major cleaning services for families who are clients in Norman class program.

4020 – YOUTH IN CRISIS – HOUSING ADVOCACY GRANT

Grant to assist DCFS youth in obtaining and maintaining stable housing.

4021 – YIC/YIT HOUSING ADVOCACY

A new Housing Advocacy Program in FY02 to assist DCFS youth in obtaining and maintaining stable housing. The first year of this program (FY02) the type of service code was established to be identified as a grant. In FY03, it will be identified as a fee for service.

4022 – YIC/YIT OUTREACH

A new Housing Advocacy Program in FY02 to assist DCFS youth in obtaining and maintaining stable housing. The first year of this program (FY02) the type of service code was established to be identified as a grant. In FY03, it will be identified as a fee for service.

4102 – PRIVATE AGENCY LICENSED TRADITIONAL – PCS CONTRACTS

Monthly board rate payment to private agency for ward in a licensed traditional foster home.

4140 – PRIVATE AGENCY LICENSED RELATIVE – PCS CONTRACTS

Monthly board rate payment to private agency for ward in a licensed relative foster home.

4201 – ADVANCE TO CASH ASSISTANCE

Youth Housing Assistance—Transitional (YHAT) Start-up grant will be available for emancipating wards who show ability to cover future living expenses.

4202 – SHELTER/SECURITY DEPOSIT/YIT

Youth Housing Assistance—Transitional (YHAT) Security Deposit for emancipating wards who show ability to cover future living expenses.

4203 – SHELTER/1ST MONTH'S RENT/YIT

Youth Housing Assistance—Transitional (YHAT) 1st month's rent for emancipating wards that show ability to cover future living expenses.

4204 – SHELTER/RENT ARREARS/YIT

Youth Housing Assistance—Transitional (YHAT) rent arrears for emancipating wards that show ability to cover future living expenses.

4205 – PARTIAL RENT SUBSIDY

Youth Housing Assistance—Transitional (YHAT) monthly rental subsidy paid to the youth or directly to the housing provider for youth whose rent is more than 30% of their income.

4206 – UTILITIES/ARREARS/YIT

Youth Housing Assistance—Transitional (YHAT) utilities arrears for emancipating wards that show ability to cover future living expenses.

4207 – UTILITIES/INITIAL COSTS/YIT

Youth Housing Assistance—Transitional (YHAT) initial costs for emancipating wards who show ability to cover future living expenses.

4208 – FOOD/YIT

Youth Housing Assistance—Transitional (YHAT) food for emancipating wards who show ability to cover future living expenses.

4209 – ADMINISTRATIVE FEE

Administrative costs related to administering the Youth Housing Assistance—Transitional (YHAT) program

4212 – BEDS/YIT

Youth Housing Assistance—Transitional (YHAT) beds for emancipating wards who show ability to cover future living expenses.

4214 – MISCELLANEOUS/YIT

Youth Housing Assistance—Transitional (YHAT) miscellaneous expenses for emancipating wards who show ability to cover future living expenses.

4216 – FURNITURE/YIT

Youth Housing Assistance—Transitional (YHAT) furniture for emancipating wards who show ability to cover future living expenses.

4302 – SHELTER/SECURITY DEPOSIT/YIC

Youth Housing Assistance—Crisis (YHAC) security deposit to prevent homelessness for youth who encounter a temporary crisis and show ability to cover future living expenses.

4303 – SHELTER/1ST MONTH'S RENT/YIC

Youth Housing Assistance—Crisis (YHAC) 1st month's rent to prevent homelessness for youth who encounter a temporary crisis and show ability to cover future living expenses.

4304 – SHELTER/ADDITIONAL RENT/YIC

Youth Housing Assistance—Crisis (YHAC) additional rent to prevent homelessness for youth who encounter a temporary crisis and show ability to cover future living expenses.

4305 – SHELTER/REPAIRS/YIC

Youth Housing Assistance—Crisis (YHAC) repairs to prevent homelessness for youth who encounter a temporary crisis and show ability to cover future living expenses.

4306 – UTILITIES/ARREARS/YIC

Youth Housing Assistance—Crisis (YHAC) utilities arrears to prevent homelessness for youth who encounter a temporary crisis and show ability to cover future living expenses.

4308 – FOOD/YIC

Youth Housing Assistance—Crisis (YHAC) food to prevent homelessness for youth who encounter a temporary crisis and show ability to cover future living expenses.

4311 – CLOTHING/YIC

Youth Housing Assistance—Crisis (YHAC) clothing to prevent homelessness for youth who encounter a temporary crisis and show ability to cover future living expenses.

4312 – BEDS/YIC

Youth Housing Assistance—Crisis (YHAC) beds to prevent homelessness for youth who encounter a temporary crisis and show ability to cover future living expenses.

4313 – TRANSPORTATION/YIC

Youth Housing Assistance—Crisis (YHAC) transportation to prevent homelessness for youth who encounter a temporary crisis and show ability to cover future living expenses.

4314 – MISCELLANEOUS/YIC

Youth Housing Assistance—Crisis (YHAC) miscellaneous costs to prevent homelessness for youth who encounter a temporary crisis and show ability to cover future living expenses.

4315 – KITCHEN APPLIANCES/YIC

Youth Housing Assistance—Crisis (YHAC) kitchen appliances to prevent homelessness for youth who encounter a temporary crisis and show ability to cover future living expenses.

4316 – FURNITURE/YIC

Youth Housing Assistance—Crisis (YHAC) furniture to prevent homelessness for youth who encounter a temporary crisis and show ability to cover future living expenses.

4901 – INTERIM PAYMENT – PROSPECTIVE PLACEMENT

Payment to interim caregiver for care of adopted/subsidized guardianship child of deceased/incapacitated parent/guardian. Based on the interim caregiver moving toward adoption/guardianship. (See below Type Service Code 4999 for payments prior to the signed Interim Agreement)

4902 – OUT OF HOME – PURCHASE OF SERVICE FOSTER CARE PLACEMENT

Requires Director's Office approval.

4999 – INTERIM PAYMENT – PRIOR TO SIGNED INTERIM AGREEMENT

5000 – CHILD ABUSE AWARDS AND GRANTS

5045 – MISCELLANEOUS/EXTENDED SERVICES

5700 – COMPREHENSIVE COMMUNITY BASED SERVICES

Payments for services to both open cases and community families and children without an open case which are not otherwise available through DCFS or community providers and usually provided through Local Area Networks at actual costs up to contractual limits.

6009 – FOSTER CARE EXEMPT – UNLICENSED TRADITIONAL PLACEMENT

Monthly support payment paid directly by DCFS to traditional foster homes that are not licensed, but serviced by the POS agency under unique programs not classified as specialized foster care. Admin cost to private agency.

6099 – FOSTER CARE EXEMPT – UNLICENSED RELATIVE PLACEMENT

Monthly support payment paid directly by DCFS to relative foster homes that are not licensed, but serviced by the POS agency under unique programs not classified as specialized foster care. Admin cost to private agency.

6101 – UNLICENSED TRADITIONAL DEPARTMENT BOARDING HOME

Payments for DCFS supervised unlicensed home for traditional foster care.

6102 – UNLICENSED TRADITIONAL PRIVATE AGENCY BOARDING HOME

Payment for private agency supervised unlicensed foster care homes.

6103 – UNLICENSED TRADITIONAL DEPARTMENT - INTENSIVE

Payments made to the DCFS supervised unlicensed home for intensive level of foster care.

6104 – UNLICENSED TRADITIONAL DEPARTMENT - EMERGENCY

Payments for DCFS supervised unlicensed home due to emergency reasons when homemaker services is impractical or when neglect, abuse or family crisis necessitates immediate placement.

6106 – UNLICENSED RELATIVE DEPARTMENT PLACEMENT

Payments for DCFS supervised unlicensed relative home.

6107 – UNLICENSED TRADITIONAL DEPARTMENT - REDUCED RATE

Payments for DCFS supervised unlicensed home for traditional foster care at a rate lower than regular rates.

6114 – UNLICENSED TRADITIONAL DEPARTMENT - SPECIALIZED

Payments for DCFS supervised homes for specialized foster care.

6137 – UNLICENSED PRIVATE AGENCY HOME - DELEGATED RELATIVE AUTHORITY

Payments to delegated unlicensed relative for child managed by private agency.

6140 – UNLICENSED RELATIVE - PRIVATE AGENCY

Payments to unlicensed relative for child managed by private agency.

6144 – UNLICENSED TRADITIONAL DEPARTMENT SPECIALIZED

Payments for DCFS supervised home for unlicensed specialized foster care that was approved prior to 5/2/02.

6169 – UNLICENSED HMR AGENCY SPECIALIZED – HIV

Payments to unlicensed relative providing specialized care for HIV child managed by a private agency.

6187 – ADMIN SMALL COOK PERFORMANCE

Administrative rate for foster homes.

6188 – ADMIN SMALL COOK PERFORMANCE

Administrative rate for foster care.

6191 – ADMIN DOWNSTATE PERFORMANCE

Administrative rate for foster care.

6196 – VOUCHER PAYMENT PRIVATE AGENCY MEDICALLY COMPLEX (6169)

6197 – UNLICENSED AGENCY ADMINISTERED DEL RELATIVE AUTHORITY

6198 – ADMIN DOWNSTATE PERFORMANCE

Payments to foster homes supervised by private agency.

6903 – HMR CHILD IN UNLICENSED INTENSIVE FOSTER CARE

Payments to unlicensed relative home for more intense level of care to children with physical, mental or behavioral conditions.

6914 – UNLICENSED HMR DEPARTMENT SPECIALIZED FOSTER CARE

Payments to unlicensed relative home for specialized care to children with physical, mental or behavioral conditions supervised by DCFS.

6944 – UNLICENSED RELATIVE DEPARTMENT SPECIALIZED FOSTER CARE

Payments for DCFS supervised unlicensed relative home for specialized foster care approved prior to 5/2/02.

6967 – PREGNANT PARENTING TEEN – ILV UNLICENSED RELATED

7100 – MEDICAL OPTION SERVICES

7109 – MEDICAID/AGENCY SPECIALIZED FOSTER CARE

Payments to a private agency for specialized foster care population (children with physical, mental or behavioral conditions or pregnant girls); provider is Medicaid certified.

7190 – MEDICAID/ADVANCE PAYMENT

Advance payment to Medicaid certified provider as negotiated by contract.

7201 – MEDICAID/PRIVATE INSTITUTIONS

Payments to a licensed private child care institution under contract to DCFS; provider is Medicaid certified.

7202 – MEDICAID GROUP HOME FEE FOR SERVICE

7203 – MEDICAID/PRIVATE GROUP HOMES

Payments to a licensed group home under DCFS contract; provider is Medicaid certified.

7204 – MEDICAID/SUPERVISED INDEPENDENT LIVING

Payment for supervision of youth 16 through 20 years of age in independent living arrangements by licensed child welfare agencies as negotiated by contract.

7205 – MEDICAID/INDEPENDENT LIVING FEE FOR SERVICE

7221 – MEDICAID/EMERGENCY SHELTERS-INSTITUTIONS

Payments to a licensed, Medicaid certified institution for providing emergency shelter.

7240 – OUT OF HOME – INSTITUTION/GROUP HOME – MEDICAID

7267 – MEDICAID/PREGNANT PARENTING – TEEN RESIDENT

7268 – MTL – TRANSITIONAL LIVING MEDICAID PROGRAM

Transitional Medicaid Program typically requires a level of on site supervision for a portion or all of a day, seven days a week, with a minimum requirement that youth receive on-site staff supervision during all times consistent with local curfew ordinances. MTL service has a goal enhancing the individual's education, training, skills and development toward basic self-sufficiency so as to prepare for transition to a less supervised setting, or to an unsupervised level of service, or adulthood.

7291 – MEDICAID POS CASE OVER 21 YEARS OF AGE

Requires Director's Office approval.

7709 – LICENSED TRADITIONAL MEDICAID AGENCY SPECIALIZED FOSTER CARE

Payments to a private agency for licensed specialized foster care (children with physical, mental or behavioral conditions or pregnant girls); provider is Medicaid certified.

7909 – HMR LICENSED MEDICAID AGENCY SPECIALIZED FOSTER CARE

Payments to licensed relative for DCFS supervised home; provider is Medicaid certified.

8001 – WRAP SERVICES FOR DCFS CLIENTS

Payment for comprehensive packages of individually tailored services developed by Local Area Networks (LANS) to meet particular children's needs. The services help children avoid placement in increasingly restrictive settings. They include maintenance at home with their families, placement in less restrictive settings, or return home.

8002 – STEP DOWN SERVICES FOR DCFS CLIENTS

8003 – SYSTEM OF CARE

8886 – RECEIVABLES/MISCELLANEOUS

Miscellaneous receivable to be charged to a receivable account for overpayments not related to board services or payments made in error related to an original payment not requiring a service type code.

8887 – RECEIVABLES/PENALTY-SHORTFALL

Receivable to represent a penalty charged to an account for some type of non-compliance.

8888 – OTHER RECEIVABLES/EXCESS REVENUE

9009 – FOSTER CARE EXEMPT – LICENSED TRADITIONAL

Payment to a private agency for licensed traditional services in unique programs not classified as specialized foster care.

9099 – FOSTER CARE EXEMPT – LICENSED RELATIVE

Payment to a private agency for licensed relative services in unique programs not classified as specialized foster care.

9101 – LICENSED TRADITIONAL DEPARTMENT BOARDING HOME

Payments to licensed traditional boarding homes supervised by DCFS.

9102 – LICENSED TRADITIONAL AGENCY BOARDING HOME

Payments to licensed traditional boarding homes supervised by private agencies.

9103 – LICENSED TRADITIONAL INTENSIVE FOSTER CARE

Payments to licensed DCFS supervised homes for a more intense level of care to children with physical, mental or behavioral conditions.

9104 – LICENSED TRADITIONAL EMERGENCY FOSTER CARE

Payments for licensed placement on emergency basis.

9106 – LICENSED RELATIVE DEPARTMENT BOARDING HOME

Payments for DCFS supervised licensed home of relative.

9109 – LICENSED TRADITIONAL AGENCY SPECIALIZED FOSTER CARE

Payments to licensed child welfare agency for care to children with physical, mental or behavioral conditions.

9114 – LICENSED TRADITIONAL DEPARTMENT SPECIALIZED FOSTER CARE

Payments to individual licensed foster parents supervised by DCFS for care to children with physical, mental or behavioral conditions.

9137 – LICENSED AGENCY DELEGATED RELATIVE AUTHORITY

Payments to private agency delegated licensed relative caregiver.

9140 – LICENSED RELATIVE PRIVATE AGENCY BOARDING HOME

Payments to private agency for licensed relative homes.

9143 – LICENSED TRADITIONAL AGENCY SPECIALIZED FOSTER CARE (CLOSED TO INTAKE CONTRACTS)

Payments to licensed child welfare agencies for children with behavioral and/or emotional problems. Specific to closed to intake contracts.

9144 – LICENSED TRADITIONAL DEPARTMENT SPECIALIZED FOSTER CARE (NO NEW PLACEMENTS EFF 5/2/02)

Payments to licensed DCFS supervised foster parents for children with behavioral and/or emotional problems approved prior to 5/2/02.

9167 – PREGNANT PARENTING TEEN – ILV LICENSED UNRELATED

9169 – HMR IN LICENSED PRIVATE AGENCY SPECIALIZED – HIV

Payments to private agency supervised licensed relative home, which is providing specialized services to a child with HIV.

9903 – LICENSED RELATIVE INTENSIVE FOSTER CARE

Payments to licensed DCFS supervised home of relative for a more intense level of care to HMR children with physical, mental or behavioral conditions.

9909 – LICENSED RELATIVE AGENCY SPECIALIZED FOSTER CARE

Payments to licensed home of relative children with physical, mental or behavioral conditions supervised by private agency.

9914 – LICENSED RELATIVE DEPARTMENT SPECIALIZED FOSTER CARE

Payments to licensed home of relative children with physical, mental or behavioral conditions supervised by DCFS.

9943 – LICENSED RELATIVE AGENCY TREATMENT FOSTER CARE (CLOSED TO INTAKE)

Payments to licensed home of relative children with behavioral and/or emotional problems supervised by private agency. Specific to closed to intake contracts.

9944 – LICENSED RELATIVE DEPARTMENT SPECIALIZED FOSTER CARE (NO NEW PLACEMENTS EFF 5/2/02)

Payments to licensed home of relative children with behavioral and/or emotional problems supervised by DCFS approved prior to 5/2/02.

9967 – PREGNANT PARENTING TEEN ILV LICENSED RELATED

DEPARTMENT OF CHILDREN AND FAMILY SERVICES

Distribution: X and Z

POLICY GUIDE 2002.03

ADOPTION ASSISTANCE/SUBSIDIZED GUARDIANSHIP EMPLOYMENT/TRAINING RELATED DAY CARE SERVICES FOR CHILDREN UNDER THREE YEARS OF AGE

DATE: February 6, 2002

TO: All DCFS and Purchase Of Service Agency Child Welfare Staff and All Rules and Procedures Bookholders

FROM: Jess McDonald

EFFECTIVE: Immediately

I. PURPOSE

The purpose of this Policy Guide is to issue additional instructions for the payment of day care services on behalf of children under the age of three who are receiving an adoption assistance or guardianship subsidy.

II. PRIMARY USERS

The primary users of these procedures are Department or purchase of service agency permanency/adoption workers, staff of regional post adoption/guardianship units and regional day care payment staff.

III. PAYMENT PROCEDURES

1) In order to receive payment for monthly day care services provided on behalf of a child under three years of age who is receiving adoption assistance or subsidized guardianship, the day care provider will complete form **CFS 420-21D, Purchased Day Care Monthly Enrollment Form**, and mail it to the regional day care payment office.

2) The payment office will:

- verify the information provided by the day care provider,
- affix the Certification of Receiving Officer and Head of Unit signatures to the form,

- enter the information into IMSA using screens VP15 (lead screen) and VP14 (detail screen), and

- forward the signed Enrollment form to the Audit and Approval Unit in Springfield.

3) Upon receipt by the Audit and Approval Unit:

- The file clerk in the Audit and Approval Unit (AAU) will date stamp the back of the Enrollment Form and enter that received date into the IMSA system using VP32.

- The AAU Account Techs will audit the Report verifying that the report information agrees with the information entered into the IMSA system (provider, contract number, appropriation, detail object, dollar amount, etc.

- After the information has been audited, the Account Techs will approve the voucher for payment via VP32.

- The next morning the file clerk will receive the paper work from Information Service Division (ISD) to process the payments.

- The Account Tech authorized to sign the Director's name will affix the Director's signature to the paper work and return the signed reports to the File Clerk.

- The File Clerk will forward the appropriate paper work to the Comptroller for processing

IV. NOTIFICATIONS TO THE ADOPTIVE/GUARDIANSHIP FAMILY AND DAY CARE PROVIDER

When a family is approved for day care payments for a child under the age of three as specified in **Procedures 359, Appendix G, Employment - Related Day Care For Adoptive Families and Subsidized Guardians with Children Under Three Years of Age**, the regional day care payment unit will send an approval letter, form **CFS 469**, to the day care provider with a supply of **CFS 420-21 D** forms for the provider's use. The payment unit will also send an approval letter, **CFS 469-1**, to the family. Copies of both letters are attached.

V. ATTACHMENTS

Form **CFS 420-21D, Purchased Day Care Monthly Enrollment Form**

CFS 469, Letter of approval sent to day care providers

CFS 469-1, Approval – Post Adoption/Subsidized Guardianship Child Care (Sent to Adoptive/Guardianship families)

The above, which are being translated into Spanish, will be available in Stores and on the SACWIS template for use by the regional day care payment units.

VI. FILING INSTRUCTIONS

File this Policy Guide with Procedures 359, Appendix G.

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APPENDIX G

EMPLOYMENT - RELATED DAY CARE FOR ADOPTIVE FAMILIES AND SUBSIDIZED GUARDIANS WITH CHILDREN UNDER THREE YEARS OF AGE

This appendix describes how to pay for employment-related day care for children under three years of age who have been adopted with adoption assistance or have been placed in subsidized guardianship.

I. Who Is Eligible?

Department wards under three years of age who have been adopted with adoption assistance or placed in subsidized guardianship are eligible if they require day care services because the parent or guardian is absent from the home due to employment or participation in a training program that will lead to employment. Payment for day care will be available to employed single parent adoptive or subsidized guardianship homes, as well as two parent adoptive homes or subsidized guardianship homes in which both spouses are either working or in a training program. Adoptive parents and subsidized guardians must provide documentation that they are working or in a training program. If one parent or guardian works and the other parent or guardian is unable to care for the child due to a disability, day care may be provided. The disability must be documented. Eligibility for employment related day care will be redetermined every six months by the regional day care staff.

II. Eligible Day Care Providers

The types of day care that may be authorized are licensed day care centers and homes, home networks, and license-exempt day care centers, licensed exempt homes, baby-sitters (care in the child's home) and relatives. Adoptive parents or subsidized guardians may choose their own providers.

DCFS staff will conduct a check of the Child Abuse and Neglect Tracking System on all license exempt providers. If the check shows that there is an indicated report, the provider is ineligible.

III. Application and Payment

This section describes procedures for application for employment-related day care for adoptive families and subsidized guardians with children under three years of age and for payments to day care providers for ongoing day care services until the child reaches 3 years of age.

Payments will be made directly to the day care provider.

Payment will be made based upon the provider's rates to the general public up to the regular allowable rate maximums which are listed in Appendix A of this Procedure. Full time care is defined as five or more hours in a 24-hour day. Payments will stop at the end of the month in which the child turns three years of age. Payments are to be billed under the child's adoption or subsidized guardianship ID number.

To initiate payments the following procedures are to be followed:

a) Starting the Application Process

1) First Time Day Care or New Provider

If this is a case in which the family was not receiving day care services for the child as a foster parent/ relative caregiver or they were receiving services from a particular provider, but are changing day care providers then:

At the time the adoption assistance/subsidized guardianship payments are being negotiated and completed with the family, the Permanency Worker shall complete the first page of the **CFS 2000, Day Care Services Application** and give the family the **CFS 2000, Parts I and II.** The family shall complete the form with their new day care provider. **Part III** of the form must be completed by the Permanency Worker for providers that are exempt from licensing.

2) Continuance of Day Care Services Provided During Foster/Relative Care

If the family was receiving day care services for the child as a foster parent/relative caregiver and are to continue receiving payment for day care under the adoption assistance/subsidized guardianship agreement and there is no change in the provider then:

At the time the adoption assistance/subsidized guardianship payments are being negotiated and completed with the family, the Permanency Worker shall complete the fist page of the **CFS 2000, Day Care Services Application** and give the family the **CFS 2000** for completion of **Part I** only.

b) Upon Completion of the Form

After the adoption or transfer of guardianship has been finalized, the family, after having completed the **CFS 2000** in accordance with either paragraph (A) or (B) above, shall return the form to the Permanency Worker. The Permanency Worker will forward the application to the appropriate regional unit responsible for day care payments.

The regional unit responsible for day care payments will begin payment after the family's case has been transferred to the Post Adoption Unit and the Adoption Assistance/Subsidized Guardianship Case has been opened. In the case of adoption assistance, billing will be made under the new case ID number. For subsidized guardianship, the case retains the foster care ID number and billing is made under that number.

The regional unit responsible for day care payments will pay the day care provider for services at the end of each month using the appropriation code and type service codes established for adoption assistance/subsidized guardianship day care.

Appropriation Code: 220-41817-4400-05-00

Type Service Codes:

0361--AA/SG Daycare--Licensed Day Care Center
0362--AA/SG Daycare--Licensed Exempt Center
0363--AA/SG Daycare--Licensed Day Care Home
0364--AA/SG Daycare--Licensed Exempt Home
0365--AA/SG Daycare--Home Network
0366--AA/SG Daycare--Non-Relative Childs Home
0367--AA/SG Daycare--Relative Relatives Home
0368--AA/SG Daycare--Relative Childs Home
0369--AA/SG Daycare--Licensed Group Day Care Home

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APPENDIX H

COMPREHENSIVE MEDICAID BILLING SYSTEM (CMBS)/ MEDICAID BILLING SYSTEM (MBS)

I. Purpose

To comply with the requirements of the Health Insurance Portability and Accountability Act (HIPAA) these procedures have been developed to describe the Comprehensive Medicaid Billing System (CMBS) and the Medicaid Billing System (MBS) and who must use it.

II. Primary Users

The primary users of these procedures are all providers of 59 Ill. Adm. Code 132, Medicaid Community Mental Health (MCMH) Services and DCFS "Production Control" staff who receive, handle or transmit Part 132 billing information.

III. What is the Comprehensive Medicaid Billing System (CMBS) and Medicaid Billing System (MBS)

The DCFS Medicaid Billing System is the system through which Medicaid services are claimed to DCFS and the Illinois Department of Public Aid (IDPA). Providers submit claim data concerning MCMH Services provided to children under their contracts. Claiming occurs on a monthly basis via computer diskette through the Department's CMBS/MBS. This information is due no later than the last State of Illinois working day after the month in which service was provided.

The CMBS/MBS involves the use of a personal computer system by each agency for entry and correction of the claims to be submitted. DCFS provides this software free of charge to all agencies involved.

IV. Using the CMBS/MBS

1) General Expectations of DCFS Medicaid Providers

Medicaid Community Mental Health Services providers submit billing data for the provision of Medicaid services to clients served under a DCFS Medicaid contract as follows:

a) **Submittal of Billings:** Medicaid providers submit billings for services in the format and medium specified by the Department no later than the last State of Illinois working day after the month in which services were provided. If the provider fails to submit the required billings, the Department reserves the right to suspend payment of the Medicaid portions of the rate, and/or to recoup monies paid to the provider for Medicaid services.

b) **Re-Submittal of Rejected Billings:** Medicaid providers re-submit billings previously rejected by either the Department or the Illinois Department of Public Aid for a correctable error on the next billing cycle due to the Department after the provider's receipt of notice of the rejected billings.

c) **Third-Party Payments:** All initial billings and previously rejected billings shall, as necessary, contain information concerning the amount of any payment the provider received from a third-party for services provided to an individual child.

2) Billings Processing By DCFS

When the Department receives billings from the provider as required above, the Department will edit the billings and return to the provider a file of records for correction within 15 days of the established cut-off dates. The cut-off date is the last working day of each month. Billings that are acceptable to this editing process will be forwarded to IDPA for approval.

3) Billing Requirements—Substitute Care Contracts

a) **Comprehensive Services:** Medicaid providers submit to the Department's Financial Management Division by the fifth working day of each month the Monthly Claim Statement listing of children served during the previous month and the inclusive list of dates of service for each child. The Monthly Claim Statement shall be the basis for determining the total amount of payment due to the provider based on the per diem rate. (The per diem rate consists of a Medicaid and Non-Medicaid/room and board portion.) Failure to comply with this section may result in payment interruption or contract termination. The provider shall submit Medicaid billings equal to or in excess of the total amount stated in the contract as support documentation for previous payments for Medicaid Community Mental Health Services. Therefore, the provider shall submit billings equal to or in excess of the number of days of care multiplied by the Medicaid portion of the rate.

Monthly payment for Comprehensive Mental Health/Rehabilitative Services will be made through the automated board payment system. The Department will prepare a reconciliation report for each DCFS Medicaid substitute care contract to verify that all billing information has been submitted and that any billings returned due to errors have been corrected and resubmitted.

If the provider fails to comply with the requirements for Comprehensive Services billing, service provision, or documentation requirements as outlined in the provider's program plan, the Department may revoke the provider's ability to provide Comprehensive Services. As a result, the Department may then require the provider to submit Fee-for-Service billing for Medicaid services.

The maximum Medicaid billings for which the provider may receive revenue is limited to the total days of care provided multiplied by the Medicaid per diem rate. Any Medicaid revenue received by a provider in excess of the reconciled Medicaid billings will be refunded to the Department or withheld from monies due the provider.

b) **Fee-for-Service:** Medicaid providers submit to the Department's Financial Management Division by the fifth working day of each month the Monthly Claim Statement listing of children served during the previous month and the inclusive list of dates of service for each child. The Monthly Claim Statement shall be the basis for determining the total amount of payment due to the provider based on the non-Medicaid portion of the full per-diem rate. Failure to comply with these requirements may result in payment interruption or contract termination.

The provider submits bills equal to or in excess of the total amount stated in the contract as payment for Medicaid Community Mental Health Services. Therefore, the provider shall submit billings equal to or in excess of the number of days of care multiplied by the Medicaid portion of the rate.

Payment for Medicaid Community Mental Health Services will be made on the basis of actual billing levels received and accepted by the Medicaid Billing System. The Department will prepare a reconciliation report for each DCFS Medicaid substitute care contract to verify that all billing information has been submitted and that any billings returned due to errors have been corrected and resubmitted.

For those billing months in which the billing reconciliation yields a net amount due to the provider, the Department will initiate a voucher payment. The maximum Medicaid billings for which the provider may receive revenue is limited to the total days of care provided multiplied by the Medicaid per diem rate. Any Medicaid revenue received by a provider in excess of the reconciled Medicaid billings will be refunded to the Department or withheld from monies due the provider.

4. Billing Requirements—Non-Substitute Care Contracts

a) **Counseling:** Medicaid counseling providers submit billing claims for services delivered to Medicaid eligible and non-Medicaid eligible clients served under the contract. Payments will be issued based on reconciled utilization information and a comparison with referral for service authorizations.

b) **SASS:** SASS providers submit bills for Medicaid Community Mental Health Services that equal or exceed a designated percentage of the maximum payable amount under the SASS contract. Payments will be issued based on the cash flow payment schedule outlined in the program plan.

V. Billing Processing

Once the CMBS/MBS billing diskette is sent by the provider to DCFS, the diskette is logged in as received by the Office of Contract Administration, Medicaid and Non-Board Services. The billing information is then uploaded on personal computer for initial verification of readable data. If the data is readable, a letter is sent to the provider confirming receipt and readability. The readable billing data is then batched and loaded to a DCFS mainframe "host" system. This billing data is then held until the regularly scheduled billing processing cycle. The mainframe and billing processing cycles are managed by the Department's Office of Information Systems. Reports by the Office of Information Systems are produced at several points in the billing processing cycle to provide a quality assurance check on the process. These reports serve to provide both alerts to any problems in the billing cycle (occurs two days before the final processing occurs) or actual print-outs regarding the results of the entire billing cycle.

Any reports that are generated are routed to the appropriate staff for monitoring/use. Report distribution includes the Department's Office of Financial Management for use in substitute care contract payment reconciliation and generation, the Office of Contract Administration for overall system integrity and interface with providers regarding the results of the billing cycles, and the Office of Contract Administration for payment and reconciliation on the SASS and Counseling contracts.

Any billings submitted via diskette that do not process cleanly through the billing processing cycle (e.g., because client names, ID's or other details are incorrect), are returned as errors to the Office of Contract Administration for error diskette generation. These error diskettes are returned to the providers for uploading onto their CMBS/MBS allowing for the error correction process described in section 1.b. above.

Once the billings are processed and verified as "valid" bills submitted by the provider, these valid bills are then submitted to the Illinois Department of Public Aid (IDPA) as Medicaid claims. IDPA then validates the claims against their system edits, and all valid claims are then submitted to the federal government for federal financial participation matching funds.

VI. Handling CMBS/MBS Computer Files

Due to the new HIPAA regulations specifying privacy requirements of a covered entity's HIPAA – covered functions, the handling of CMBS/MBS billing data must be tightly controlled. Any CMBS/MBS billing data received from a provider is processed and edited for validity. During this processing and editing of billing data, computer files are generated and routed through the DCFS "Production Control" unit for dissemination to the appropriate users of the data. All billing data from the CMBS/MBS processing cycle is confidential client information and cannot be viewed by Production Control staff. Only computer file configurations and status regarding its passage through Production Control can be viewed. At no time can the contents of the computer files from the CMBS/MBS system be accessed without the express authorization of the Administrator, Medicaid Services.

VII. Questions

MBS Technical Support

Computer system problems or software questions	(217) 524-3560

Office of Financial Management

Institution, Group Home, Foster Care & Independent Living payment questions	(217) 785-2704

Office of Contract Administration

Status of your billing or error diskette	(217) 524-3304
Counseling Contract billing or payment questions	(217) 557-2458
SASS contract billing or payment questions	(217) 785-0200

The Infant-Parent Institute

Medicaid Rule 132 interpretation or billing issues not specified above

Champaign	(217) 352-4172
Matteson	(708) 503-8431

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